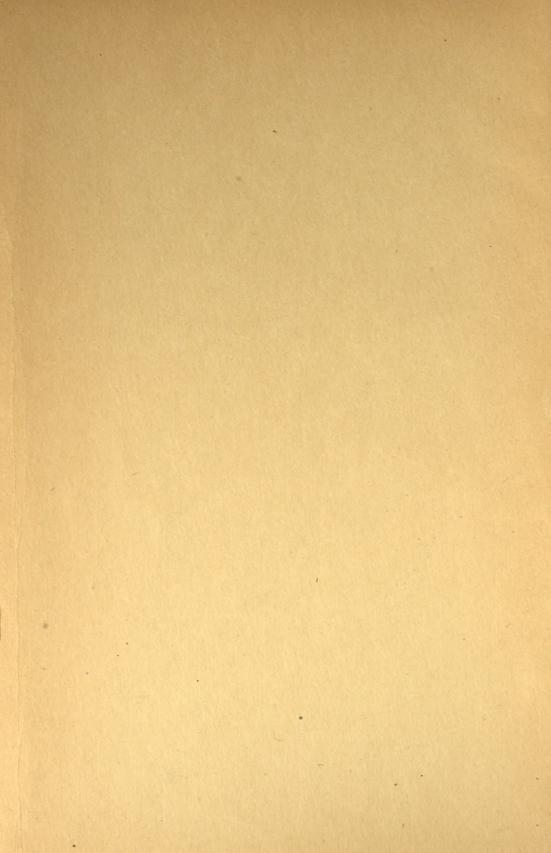
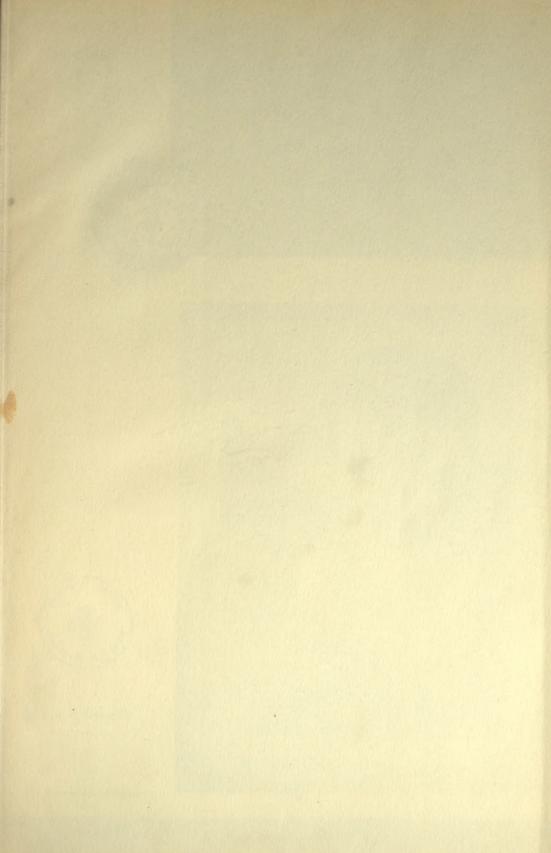
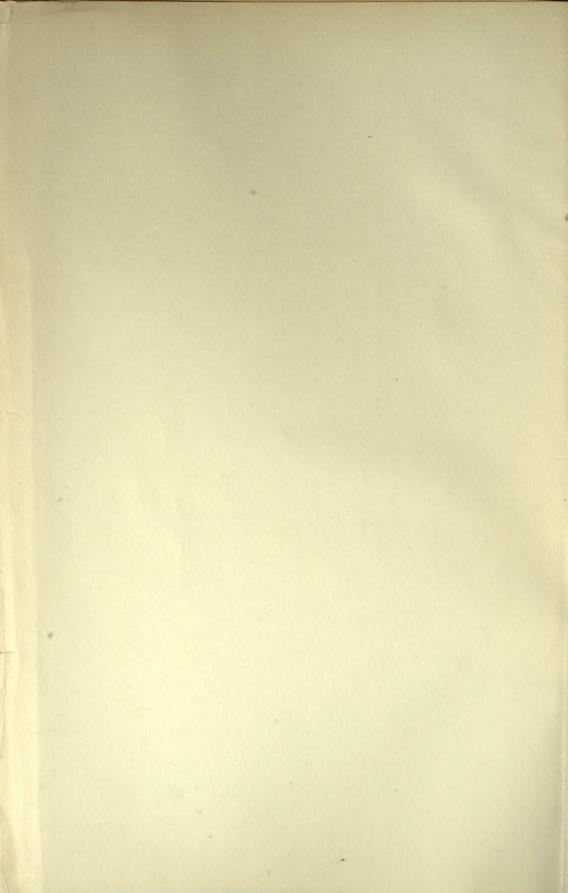


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VOLUME 41 NUMBER 1

> JANUARY 1 9 4 5

CANADIAN NURSE







Young Canada of 1945

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NURSING PROFESSION

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	AVERAG	E ANEMIC	LEVELS	AVERAGE AFTER 6 WEEKS OF FEEDING			
Groups of Rats	Body Weight CM	Hemo- globin GM, per 100 CC Blood	R. B. C. Millions per CMM	Body Weight CM	Hemo- globin GM per 100 CC Blood	R. B. C. Millions per CMM	
Combination No. 3 Strained Spinach	95 96	4.2	2.55	170 147	12.5 10.4	6.11	

It is evident from the data tabulated above that the group of rats fed the combination of vegetables showed average increases of 197 per cent in hemoglobin and of 143 per cent in red blood cells above the respective anemic levels. On the other hand, the group of rats receiving equivalent amounts of iron as strained spinach gave average increases

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FATHERS OF CANADIAN MEDICINE



DR. MABANE studied medicine in Edinburgh, the city of his birth. After practising briefly, he is believed to have acted as Surgeon's Mate on one of the King's vessels. Following this experience, he sailed to America to join Amherst's forces, landing in New York in 1758. He was at Crown Point, N.Y., 19 days before the invasion of Quebec.

A letter of introduction from Lord Elibank to his son, General Sir James Murray probably resulted in Mabane's remaining to practise medicine in Quebec after the conquest. When Murray became Governor in 1764, he named Mabane to his first Council and appointed him a judge of the Court of Common Pleas and of the Surrogate Court.

Mabane not only continued his medical work but also served as a Councillor and on the Bench under three Governors, Murray, Haldimand and Carleton (Dorchester), the latter of whom removed Mabane from the Council in 1767 only to reinstate him in 1774. Dr. Mabane remained on the Bench throughout, however, and his judgments were noted for clarity and regard for the common weal—a fact which won him many friends but also a few unscrupping.

lous enemies who made strong but unsuccessful efforts to unseat him in 1783.

When American invasion under Benedict Arnold threatened in 1775, Mabane was entrusted with many important missions and supplied lists of parishes and old officers of militia who would serve. He was Surgeon of the Garrison Hospital when Carleton arrived after fleeing from Montreal.

Although Dr. Mabane maintained his connections with the General Hospital and the Garrison Hospital while pursuing his career as a Jurist, he gave up his private practice.

Dr. Mabane was unmarried. He died on January 5th, 1792, from pneumonia due to a cold contracted on the Plains of Abraham where he lost his way in a blizzard. He had a sister Isabel, who survived him.

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Reader's Guide

Dr. Samuel R. Laycock has had frequent contact with nursing groups through refresher courses and is thoroughly familiar with the mental hygiene needs of this group. One of the leading psychologists in Canada, Dr. Laycock has specialized in the study of why people behave as they do. He is keenly interested in helping to iron out personality difficulties and maladjustments. Through his radio talks he exerts a wide influence. counselling and advising parents in the care and upbringing of their children. Few of us relish receiving advice and criticism but it is much more palatable when it is so sound and reasonable. In his capacity as Director of the Division on education and mental health of the National Committee for Mental Hygiene for Canada, Dr. Laycock has travelled to all parts of the Dominion and is familiar with nursing needs and problems. At present, he is acting Dean of Education at the University of Saskatchewan.

The School of Nursing, University of Toronto sponsored a series of lectures by prominent physicians early last year dealing with developments in the field of medicine that are being given emphasis during wartime. We are fortunate in having two of these to bring to our readers. Both Dr. Abram I. Willinsky and Dr. George S. Young are exceedingly well qualified to discuss their respective topics. We are glad to have this opportunity of sharing their papers with the nurses of Canada.

One of the problems confronting the nurse doing district nursing in an area remote from a doctor or a well-equipped hospital is how she is to provide the prospective mothers in her community with adequate care during pregnancy and at the confinement if her knowledge and experience is limited to the information

she received during her undergraduate training. The April 1944 issue of the Journal told of the solution which had been provided by the University of Alberta. Mrs. Barbara Eben describes the course for us in some detail. Mrs. Eben, herself a graduate of the Central Midwives Board of Scotland, served as instructor in obstetrics during this special three-months course.

H. Evelyn Mallory, B.S., R.N., who is associate professor in the Department of Nursing and Health, University of British Columbia, knows whereof she speaks in regard to head nurses. For several years she was superintendent of nurses at the Children's Hospital, Winnipeg, and later was registrar and school of nursing adviser with the Registered Nurses Association of British Columbia.

Mildred I. Walker, B.S., R.N., has prepared a short series of articles dealing with the newer approach to supervision in public health nursing. The change from the authoritarian to the present-day democratic form has strengthened the supervisory programs. Miss Walker is chief of the division of study for graduate nurses, Institute of Public Health, University of Western Ontario, London.

Mrs. Wilma Raynor was doing district work for the Department of Indian Affairs for some time. Her knowledge of the people and her skill in training the Indian women to assist her with the nursing care stood her in good stead during the typhoid epidemic.

Clear-eyed and unafraid, healthy in mind and body, young Canada of 1945 confronts a troubled world, unabashed even when our photographer caught him in his bath!



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(1)	West. J. Surg., (Obst. & Gyn., 5	1:150, 1943.
	Am. J. Obst. 8		
	Med. & Surg.,		9. (4) Med
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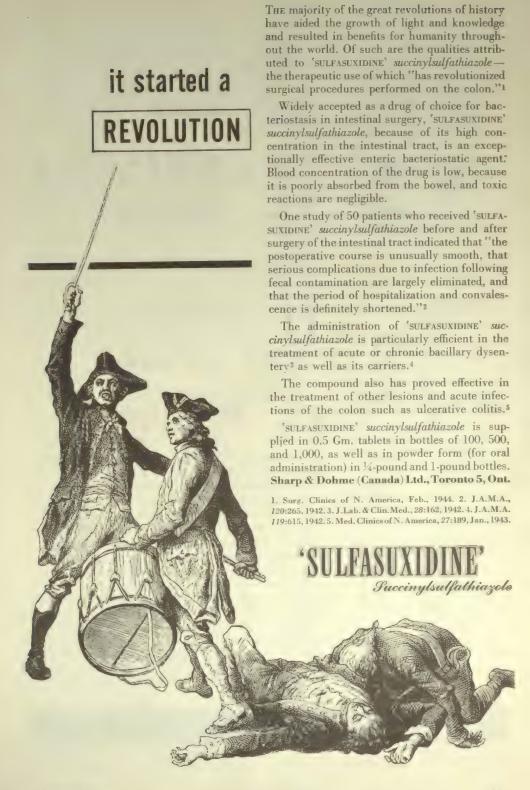
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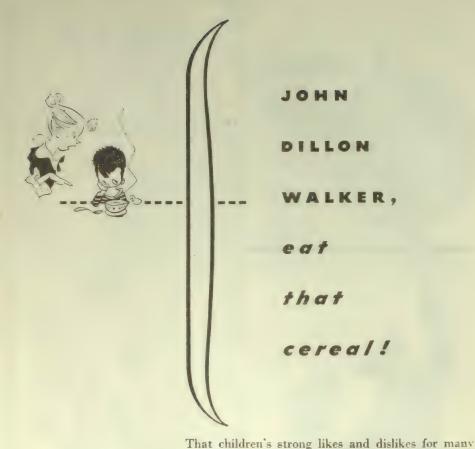
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A MONTPLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-ONE

NUMBER ONE

JANUARY 1945

"God Bless Us, Every One"

For the year now beginning I can send to Canadian nurses at home and abroad no better than the old Christmas wish of Tiny Tim "God Bless us, Every One." We begin nineteen hundred, and forty-five enjoying on the one hand great opportunities and facing on the other many problems. Everywhere nurses are doing necessary work which no one else can do so well. Government funds are available to prepare them for special work. New fields of work are opening up. There is more to be done than there are people to do it. Nonetheless we have been able to supply the necessary nurses for our fighting men and we find them far afield, caring for the wounded in Africa, Sicily, Italy, France, Belgium, Holland. Others of our members accepted for service with UNRRA are going to Albania, Poland, Greece, Yugoslavia — countries to which they probably would never have travelled had they not been nurses. All of this serves to enhance the worth of our professional training. It is because

these women are nurses that this foreign service has come their way. Let us not forget it.

Work abroad, however, is no easy thing. Many sacrifices are called for and there are dangers and discomforts which must be faced with continuous courage and determination. The privilege of foreign service also imposes obligations. Overseas nurses have the responsibility of representing Canadian nurses to the people of other countries. Our reputation for good or ill will be established abroad by the impression each of them makes on the group with whom and for whom she works. Nurses for UNRRA are selected not only on a basis of mental ability, education and nursing accomplishment. Emphasis is also placed on flexibility, loyalty, freedom from prejudice and on physical and emotional stamina. With such selection the countries to which our nurses go should think well of Canadian nurses.

The shortage of nurses at home is still acute, yet hospitals and health ser-

15

vices continue to expand. A study of health insurance plans reveals that much of what is promised to the public is dependent for fulfilment on a very large supply of nurses. Careful planning and sound thinking will be necessary if the supply is to catch up to and keep pace with the demand. A quip in a recent Reader's Digest might well apply to nursing - "Just when we think we are going to make ends meet some one shifts the ends." Except during times of depressions the shortage of nurses has always been with us and our present policy regarding preparation does not appear to be increasing the supply sufficiently. In fact it could not - controlled as it is by the size of nurses' residences and with extensions for these the last in hospital building programs instead of the first. Good nurses for all branches of nursing are needed in much larger numbers. This is specially true of bedside nursing which as far as the public is concerned is of utmost importance. What the public wants and needs must be a factor in our planning.

As a group our thinking changes slowly. Like other women we have a stake in the future. Yet we have been slow to change our ways and we have kept aloof from other groups. Some measure of care may be needed if we do not wish to be absorbed by them but a closer association would be of mutual benefit. It is, however, of greater importance for nurses to no longer hold aloof from their professional organizations. There is danger in isolation. There is danger too in being attracted by fine sounding promises. They are easily and freely made and so often result only in disappointment.

Sisters are beginning to return from overseas. As more come back they will bring with them new ideas which we may well study. We may expect them to have an impatience with our unsolved problems but we hope too they will offer practical suggestions for solving them. We are glad that government assistance will be available for the returned Sisters if they wish special preparation. It was not so following the last war when Sisters depended on themselves for their rehabilitation. Already the Canadian Nurses Association, through our post-war planning committee, has undertaken to find out wherein their interest will lie when they return, what type of preparation they wish and where. As soon as this information is complete plans will be underway to take care of the requests.

For the future may we continue to have faith in the work we are doing and faith in those with whom we work. May we see a much larger number of good nurses willing to remain with bedside nursing, looking on it as their specialty and improving their ability to handle skilfully sick bodies and anxious minds. And may our philosophy be that there is no one superior branch of nursing — no one field more important than others — no one 'best' school of nursing and no one province more endowed than others. Let the purpose of nursing be uppermost in our minds.

FANNY MUNROE

President

Canadian Nurses Association.

Preview

What causes thrombosis? Why has blood been classified into different groups? Why is a transfusion of major significance? Dr. J. J. Chesnie has an-

swered these and many similar questions in his description of "Coagulation and Thrombosis" which will appear in February.

The Mental Health of the Nurse

S. R. LAYCOCK, Ph.D.

In the past the choosing of student nurses for nurses' training schools has often been on too narrow a basis. To a large degree a fairly high standard of physical health, a Grade XI or Grade XII diploma, and a certificate of character from a clergyman or school principal have been the main entrance requirements to schools of nursing. It is true that a nurse's work does require a good physique and a capacity to learn the subjects set down in the syllabus of the training course. Mental hygienists, however, are convinced that, given a reasonably good physique, intelligence and academic training, the most important characteristic of a nurse is her personal-stimulus effect on her patients and her capacity to minister to their personality needs as well as their physical needs. There would seem, at present, only one sure way of determining this-to observe the nurse in bedside nursing situations and the actual effect which she has on her patients.

The public (and many nurses) have a very inadequate idea of the importance of bedside nursing. Many folk think of it as a high-grade maid's jobthat of bathing patients, making beds, carrying trays, taking temperatures and giving medicine at the prescribed time. It cannot be too strongly emphasized that this is not the case. The above things are important in their place. They are, however, merely a part of the process of making sick persons well. The patient is not like an automobile whose cylinder valves need re-grinding or whose spark plug needs adjusting. The patient is not a machine but a person, who has not merely a septic throat or a gangrenous appendix or a disordered liver. The patient is a complex living organism with hopes and fears, with emotional needs for affection and se-

curity, achievement, recognition and a sense of worth. The handling of these emotional needs and problems is often vitally important in the nurse's jobthat of making sick persons well. To do her job she needs more than a knowledge of anatomy. She has to understand the nature of human personality and its needs. She has to know how restoration to physical health is intimately tied up with the patient's emotional health. She has to take the major responsibility for the emotional health of the patient. After all, the physician sees the patient only once a day and for a few minutes. Ministering to sick persons and their psychological needs as well as their physical needs is the job of the nurse often for hours at a time.

How Nurses Affect Patients

In the field of education studies have been made of the effect of the teacher's personality on the behaviour of pupils. It has been found that a tense teacher has tense pupils; a "dithery" and fussy teacher has "dithery" and fussy pupils. A relaxed and unhurried manner in a teacher reflects itself in the ease and calmness with which pupils go about their work. The personal-stimulus value of the teacher is, therefore, of vital concern to all those interested in the education of children. In the field of nursing the same principles apply often with greater urgency - for persons who are ill are apt to be very sensitive to the words and attitudes of those around them. They can easily become fearful and anxious. They are in the hospital, away from their loved ones, and from familiar surroundings and from their daily routine. All of these things made life secure for them. Now, in a strange situation, in unfamiliar surroundings, separated from

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their families and jobs, and suffering physical pain they feel anxious and afraid. Such insecuriy, anxiety and fear have physiological effects. They draw on the patient's physical reserves. They hinder his recovery. It is the task of the bedside nurse to nurse the patient out of fear and anxiety and insecurity. To do this she must supply to her patient security, confidence, relaxation and a will-to-live. How effectively she does this will depend on her own inner resources - on her own soundness or unsoundness of mental health. The mental health of the nurse is often an important factor in the recovery of the patient.

WHAT MAKES NURSES MENTALLY HEALTHY

Mental health is not a mysterious sort of thing. It depends on the degree to which the individuals concerned have sound patterns of adjustment. Nurses are human beings. Like other humans they have certain basic personality needs which cannot be denied without resultant disaster. The chief of these are the needs for emotional security, independence, achievement, recognition and a sense of personal worth. Heading off mental ill-health in nurses is largely a matter of helping them to find reasonable fulfilment of these needs.

EMOTIONAL SECURITY

Next to such basic needs as that for food, every nurse needs to be loved by at feast one other human being and to feel that she is a desired and desirable member of a group — family group, friendship group, professional group or community group. All adults have to find reasonable satisfaction for this need for emotional security. Such satisfaction can be found in most complete fashion only in a happy marriage and in happy family life. Emotional security is not usually the major problem of student nurses unless they come from homes where quarrelling on the part of the

parents, or inconsistent discipline, or favoritism, or unfair treatment has made them insecure. In that case, the candidate for the school of nursing who exhibits feelings of inadequacy and insecurity should not be admitted unless there is provided a trained personnel worker or counsellor whose duty it is to give help to such individuals. Most student nurses, however, if they have a reasonable family background, find adequate security with their fellow students at the school of nursing. It is when the nurse graduates and does private nursing or becomes a supervisor or instructor that she needs help. Her duties may be exacting or her hours irregular. She may be somewhat isolated from friends and fellow-workers. Very often she does not get married. In that case she is in danger of developing "old-maid" characteristics. Old-maidishness is not confined to the unmarried or to the female sex. It is a name for a set of compensations for feelings of frustration in the realm of emotional security. These compensations are prudishness, fastidiousness, oversensitiveness, fussiness, bossiness, being too-too efficient, cattiness and trouble-making. If the graduate nurse is not going to get married, she has to look squarely in the eve the problem of meeting her need for emotional security. Since this need can be fulfilled focally only in family life, the unmarried nurse must realize that she must find it in a little more diffused fashion. She should not rely merely on her mother or sister or another unmarried nurse. She should have a circle of close friends who are fond of her and on whom she can depend. She should have friends among married couples of her own age. If she accepts the situation in which she finds herself and doesn't feel sensitive about her unmarried state she will be accepted by both partners in the homes of her friends.

Graduation is often too sudden a break for nurses. Having depended en-

tirely on classmates for her emotional security and being too often more or less shut off from normal contacts and friendships in the community the graduate nurse is often at a loss. She is backward in making friends. At least that criticism has been made, rightly or wrongly, of nurses as compared with other professional women. Schools of nursing ought to make possible more opportunities for student nurses to entertain their friends from outside, to act the part of a hostess, and to some degree to participate in social functions on the same basis as those outside the school do. Certainly the private duty nurse, the supervisor, the instructor and the administrator must make sure that their needs for emotional security are met by sound friendships and by reasonable participation in the social life of the community.

INDEPENDENCE

Every human being has a need reasonably to order his own life and to make his own decisions. This is true both of graduate and student nurses. The mental hygienist wonders about the traces of the old-fashioned kind of discipline that still persist in some schools of nursing. Good discipline is essential everywhere in life - on the street, in the theatre, in the church, on the bus - everywhere. But what is good discipline? It is merely good ways of living and working together. Furthermore discipline is a problem of social growth. It is the gradual shifting of external authority to internal authority. It is good discipline when there is an increasing amount of self-control and self-direction. The repressive discipline of the old school stifled initiative and resourcefulness - both of which qualities the nurse must have as soon as she graduates, at least, if not during her entire course. It is the business of the school of nursing to develop self-control, self-direction, initiative and resourcefulness. Otherwise the nurse will have difficulty in handling herself when she is put on her own. In addition many student nurses resent the stern discipline of the school of nursing and develop an attitude of resentment towards authority in general.

ACHIEVEMENT IMPORTANT

All human beings have basic needs for achievement and success. They need to accomplish tasks, to make things and to be creative or at least successful in their undertakings. To keep mentally healthy, nurses must find abundant satisfaction in the accomplishments of work and play. A sense of achievement through one's work is primary. Dorothy Canfield Fisher, in a recent book talks about "the vitamin of work". Burnham2 says the essentials without which a person cannot be mentally healthy are "a task, a plan and freedom." One of Wallin's3 criteria for mental health is that every individual must have a reasonable enthusiasm for the day's work and the accomplishment of worthwhile life purposes. Certainly it is vital for nurses that they taste the joys of success in the job they are doing. This means that they must continue to study and to grow in the skills and knowledge which will make them highly successful nurses. Refresher courses and graduate work should be made more accessible to them if indeed such courses should not be required for continued professional standing.

In addition to finding achievement through growth in the knowledge and skill of nursing, the nurse must seek to find emotional outlets and self-expression through hobbies and leisure time activities — art, music, literature, and in her choice of the thousand and one forms of community service through which she can share the activities of her fellow citizens. This being a part of the community and carrying one's share of community burdens is highly important for mental health and should not be overlooked. Often the nurse is

too isolated from community enterprises.

RECOGNITION AND PERSONAL WORTH

Nurses, like other folk, need recognition and a sense of personal worth. They need to feel that their work, their conduct, and their personality merit both the reasonable approval of their peers and others and also come up to their own inner standards. Self-esteem is vital to mental health. The last phrase of "Thou shalt love thy neighbor as thyself" is important. The nurse who feels "tottery" inside, inadequate and insecure is too preoccupied with her own problems to do much for her patients. Neurotic nurses may be high-grade maids but they cannot nurse persons with personality needs. In schools of nursing the old-fashioned type of discipline sometimes tried to make the student nurse feel she was unimportant and insignificant. This is unsound. Giving nurses — student and graduate real recognition for their achievements, a sense of the high importance of the nurse's job, and a genuine sense of personal worth are vital to their success. Indeed on the staff of instructors in the training school should be a personnel counsellor who would help student nurses to understand their own problems of adjustment and to rid themselves of crippling feelings of inadequacy. A course in the psychology of adjustment, rather than in academic psychology, would help student nurses to understand both their own needs and those of their patients. For graduates there should be a

definite policy of in-service education for nurses. Bulletins sent out by the professional bodies should help nurses to face their own needs for finding security, independence, achievement, recognition and a sense of worth and stimulate them to seek ways of satisfying these needs in a wholesome fashion. Perhaps, too, the professional associations could furnish some kind of a counselling and guidance service for graduate nurses which would enable them better to find the goal of mental hygiene - "a condition where each individual gives his best to the world and knows the deep satisfaction of a life richly and fully lived."

Certain it is that only as the nurse—student or graduate — finds rich satisfaction for her own needs will she be able to do that most difficult of tasks—so to minister to the emotional health of the patient that sick persons rather than merely sick bodies will become well. Indeed, unless the nurse ministers to the emotional health of her patient and shows skill in seeing that his personality needs are fulfilled she will be relatively ineffective in nursing his sick body back to health.

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Preview

Adequate staff education programs are being recognized more and more as of primary importance in the development of the whole staff in the hospital. Mrs. Edith Pringle analyzed the problem of the "Organization of the Hospital Nursing Staff". Her challenging queries should stimulate considerable thought.

Some Aspects of the Field of Urology

ABRAM I. WILLINSKY, B.A., M.B., F.A.C.S., F.R.C.S.

Although urology is generally regarded as the youngest of the medical specialties, it is in reality the oldest. Historical studies have shown that the first surgical operations ever performed on man were done chiefly on the urogenital tract. Even in the days of Hippocrates the operation of cutting for stone was so well established that its performance was relegated to a special class of practitioners. However, it has only been in the past thirty years that urology has been separated from general surgery and special departments devoted to that branch of medicine created in the larger teaching hospi-

There is no doubt that the teaching of the nursing procedures peculiar to urology has not been stressed in the past by many hospitals. This may have been due to the fact that during the development of urology, or G.U., as it is colloquially called, it has acquired an unsavory reputation in the nursing schools. The intimate relationship of urology to the sordid aspects of the venereal disease problem has contributed to this misunderstanding. Furthermore, the prudish prejudices associated with the attendance of female nurses on patients suffering with affections of the external male genitalia has caused urology to be set somewhat apart from other branches of medicine and surgery. Moreover, the offensive odours in the older, ill-ventilated urological wards and the primitive methods of hospital care of the incontinent urinous-smelling patient has led many nurses to shun the work as much as possible. In fact, in my student days, the care of urological cases was altogether in the hands of so-called male nurses or trained orderlies - who were, after all is said, graduates of the oldest of

Universities — the School of Bitter Experience.

Even though a great part of the actual care of urological cases in many hospitals is still in the hands of male nurses and trained orderlies, the nurse-in-charge is responsible for the care of the patients including supervision and instruction of orderlies. She cannot do this unless she is thoroughly familiar with all the intimate details of the urological work which they are expected to perform.

It was not until 1929 that a special text book devoted exclusively to urological nursing appeared. Since that time, three other works on this subject have been published proving that urological nursing is steadily advancing to its proper place in the nursing curriculum.

It is essential that a nurse doing urological work should have a fairly clear conception of the rudiments of the anatomy and physiology of the genito-urinary system in both the male and female. This will help to increase an understanding of the nursing problems which occur in the urological patient.

One of the great advances in the management of the urological patient has resulted from an increase of our knowledge of the physiology of water balance. It is a well-known fact that water is more essential for the wellbeing of the human organism than any other substance. It has been shown that a complete balance between available and excretory water results in maintaining the water content of the body at a fairly constant level. It is, therefore, essential that one should know something of the elementary principles underlying the mechanism of water exchange in healthy individuals before considering

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the fluid requirement of the sick individual.

Let us first consider the physiological processes of water excretion in the human. For practical purposes, only two main routes need be considered — the kidneys on the one hand and the skin and lungs on the other. The quantity of water lost in the stools is relatively insignificant and only in pathological bowel states does it play any part in the excretory side of water metabolism.

Let us now examine the important role of the lungs and skin in the question of water loss. The method of water disposal by the lungs and skin is by the process of vaporization. This vaporization plays a very important part in heat regulation and the control of body temperature. Vaporization is a steady process because at every expiration there is a definite loss of fluid in the expired air and there is continuous evaporation from the skin for there is always moisture present on the surface of the body. The estimated amount of water lost by the skin and lungs by vaporization in the normal individual, under normal conditions, is about 1500 cc. However, under abnormal conditions, such as hyperpyrexia or high environmental temperatures, this loss may go as high as 2000 cc.

One of the remarkable physiological facts is that this vaporization loss is not dependant upon the amount of the individual's water intake since the temperature regulating mechanism of the body demands at all times a constant amount of fluid regardless of the available supply. When an individual is deprived of all fluids for a considerable period the loss of water by continuous vaporization still goes on leading to dehydration of the body. The kidneys recognize, so to speak, the priority of the process of vaporization and cease excreting urine. In other words, the process of vaporization is a preferential process and must go on whether there is available fluid or not.

This brings us to a discussion of excretion of fluids by the kidneys. In the normal individual, the kidneys excrete daily about 35 gms. of waste material, dissolved in from 500 to 1500 cc. of fluid. This variability depends upon the normal concentrating capacity of the kidneys and the available water in the body. It certainly requires less work on the part of the kidneys to excrete 35 gms. of material dissolved in 1500 cc. than it does dissolved in 500 cc. of fluid. In other words, 1500 cc. is the optimal figure for urinary excretion.

The normal individual under average conditions should have available from fluids and food at least 3000 cc. of water so as to have 1500 cc. for his vaporization requirements and 1500 cc. for the solution of urinary waste material. These figures are only applicable, of course, to the healthy, not the sick. Patients who have accumulated waste products need correspondingly larger amounts of fluid for urinary excretion. This is particularly true of patients in whom the concentrating ability of the kidneys has been impaired by disease. The patient with impairment of renal function needs not only a minimum output of 1500 cc. for his daily excretion of waste but must of necessity have an output considerably in excess of this amount if he is expected to lower an elevated level of blood nitrogen. It is, therefore, apparent that the urological patient who has an elevated blood nitrogen must continue to put out urine considerably in excess of 1500 ec. in order to lower the blood nitrogen level.

In no department of medicine or surgery is it more essential for the nursing staff to measure the intake and output of fluids than in urology. It must be incorporated in the patient's record so that the water balance can be properly calculated. Not only must food and fluids taken by the patient be recorded but also the amount of vo-

mited materials and other abnormal losses, and also a relative estimate made of the degree of sweating. In considering available water for the urological patient one must remember that the 1000 to 1500 cc. which are available from the food of a normal diet may, because of diet restrictions or other reasons, be entirely lacking. In some cases as much as 6000 cc. of parenterally administered fluid may be necessary to produce 1500 cc. of urine daily. From these statements one can appreciate that in no field of surgery is a study of water balance more essential than in urology.

In the past decade there have been several important advances in urological surgery. Probably the most striking has been in the surgery of prostatic obstruction. The substitution of the closed method for the open type of prostatectomy has indeed solved many nursing problems. Electro-resection of the prostate gland, as practised to-day, has lowered not only the mortality rate but has also simplified the nursing care. Ano-

ther advance is the standardization of spinal anesthesia for urological procedures. In most clinics to-day it is recognized as the anesthesia of choice,

With the great increase in the armamentarium of the urologist, urologic procedures have become more complicated; so much so, that it is impossible in this article to go into many details. Before closing, I would like to pay my tribute to the various manufacturers of urological equipment whose accomplishment in the development of newer instruments of precision has been indeed remarkable. Improved methods of manufacturing have enabled them to produce catheters of superlative characteristics. The sterilization of the woven ureteral catheter is no longer a problem. The boiling or autoclaving of the American-made woven catheter does not cause them to deteriorate, they do not become flabby or sticky and they will retain their original degree of rigidity upon cooling - a statement which never could be said of the prewar continental-made catheter.

Training Storks for Alberta

BARBARA EBEN

Our course in advanced practical obstetrics was the answer to a very definite need within our own province. This need has been felt more acutely in the past few years as the district nursing staff has been greatly enlarged, and it has not been possible for our nurses to go to the British Isles and other places for courses in midwifery. The actual planning of the course was done by Miss Helen Mc-Arthur, Acting Director of the School of Nursing of the University of Alberta, Dr. J. R. Vant, Professor of Obstetrics, and myself as Instructor in Obstetrics. Miss McArthur and I both have had experience as district nurses. Dr. Vant, like most of our medical men, is familiar with the district nurses and their work.

We are not setting out to train midwives, but rather to give our district nurses a training that will equip them to handle maternity work in the remote parts of the province wherever they may serve. The preparation for this work includes considerably more instruction than is usually given to nurses in this country. In addition to antepartum and postpartum care designed to minimize loss of health occasioned by childbearing, these nurses must also learn to recognize and treat minor disorders, to determine which cases require hospital delivery and to get them out to a hospital before the onset of labour; this may

mean taking them a very great distance. Then they must learn to deliver the normal cases in the home, and, since there may be complications in delivery which cannot be foreseen, they must learn how to handle these.

We limited our first class to six in order to be able to give the detailed personal instruction that such a course requires. Actually we had only four students. The course was open to district nurses, or to nurses who would be acceptable as such. This year, realizing that nurses in charge of small hospitals are being obliged on occasion to deliver cases in the absence of the doctor, we are opening our enrolment to any nurse who can demonstrate her need of such a course. As all of our students have had at least three months maternity work in the course of their general training, and as most of them have had considerable experience in maternity work since, we felt that they should be able to cover the ground adequately in three months. I had felt very definitely, following my six months course with the Central Midwives Board in Edinburgh that, excellent as it was, I could have derived equal benefit from a three-months course from which the bedmaking, bedpans, and other tasks not part of a new learning experience had been eliminated. This was the impression of other nurses who had taken similar courses after training and experience in maternity nursing.

The first two months were spent in instruction in classroom and hospitals. Dr. Vant gave three hours lectures each week. The students taking their final year in public health nursing received these lectures too. They were quite the best lectures on obstetrics that I have heard given to nurses; always practical and to the point and never above the heads of the students. In addition to what might be called "straight obstetrics", he dealt with such subjects as abortions, displacements of the uterus, vaginal discharges, the menopause and other gyn-

aecological conditions. And always he taught from the angle of the prevention of disabilities caused by child-bearing. Dr. Margaret Hutton, assistant to Dr. Vant, gave mannikin practice to the four students. This covered practice in all the mechanisms of labour, demonstrated by each student with a foetus and the mannikin mother. They diagnosed the position of the foetus, put it through its various movements, and then delivered it. Pelvimetry they learnt on actual antepartum patients, and had some good classes on repair of episiotomy and lacerations, and on chloroform anaesthesia. (As the district nurses have to work at night with open coal oil or gasoline lamps, ether is out of the question, and the anaesthetic used is a few inhalations of chloroform in the second stage). Dr. D. B. Leitch, Professor of Paediatrics, gave three lectures on care of the newborn and premature infant, and the treatment of various disorders.

Since there were very few maternity patients in our out-door clinic, the obstetricians were kind enough to allow our students to attend their office examinations. Each student spent every afternoon for two weeks in a doctor's office, and all were most enthusiastic about the value of this experience.

My classroom teaching was a matter of covering the whole field, partly in review, filling in various gaps, drilling the students on such points as measurements of the pelvis, measurements of the foetal skull, and the nursing aspects of maternity care. Needless to say, with only four students each class was an open forum.

Three days a week the students spent in the two teaching hospitals observing. This did not mean that they stood about idle. They wore hospital uniforms and went on duty in the case rooms. We felt that they profited more by attending a patient during several hours of labour and then assisting at her delivery, than by arriving in the case

room just in time to witness a delivery. Accordingly we urged them to follow a case through, even if it meant staying on duty in the evening. This they did, and then when the case rooms ran into a slack spell, I went to the hospitals and we made rounds among the antepartum patients who seemed not to mind the students' attempts to diagnose foetal positions. We always explained to the patient that these were nurses who worked far out in the country where there were no doctors, and that they were taking a special course in maternity work, and the patients invariably appeared pleased to be able to help us. The doctors, who have never failed us district nurses, taught as they delivered, and were always ready to explain and to answer questions. The nursing supervisors of the maternity wards were very good in checking the students' rectal examinations. The students wrote detailed studies of each of their cases and followed up the progress of mother and child during the stay in hospital. These case studies followed an outline designed

to teach the student what to observe, and much benefit was derived.

Finding sufficient cases was our greatest difficulty. In Edmonton, there are large classes of medical students requiring all the case material they can get. One institution was able to provide us with excellent antepartum material and a few cases. In their final month, the students went out into some of our own district nursing centres where a number of cases were booked. For these four particular students who had already had considerable experience before entering for the course the number of cases obtained was felt to be fairly adequate, but in a more mixed group of students it might not be. We would like to see each student deliver, under supervision, twenty cases which she has attended during labour and will be able to observe during the puerperium. We believe we shall be able to establish this for the next group.

We are looking forward to our next class, and to building up on the founda-

tion which is laid.

Growing Old Gracefully

GEORGE S. YOUNG, M.D.

According to recent American statistics life expectancy at the beginning of this century was forty-seven years, whereas now it is sixty-three. In 1900 about 17 per cent of the population had passed the age of forty-five while in 1942 the survivals beyond that age had risen to 26 per cent. It can be estimated on the basis of these figures that in another forty years about 40 per cent of our living citizens will be at least forty-five years old. Of course old age does not begin at forty-five but the present rapid advance in life expectancy indicates that old age will require more attention than it has had in the past.

Old age has a right to complete financial security and legislation is moving in that direction. And yet to be entirely dependent on the state is not satisfactory as long as one can do even a limited amount of work. So far, governments have been slow to recognize that there is such a thing as partial disability. In view of the increasing prevalence of old age our legislators may have to provide opportunities for light employment of the older members of the community who otherwise would have no chance in a competitive labour market.

From the beginning of history there has been diversity of opinion as to the

desirability of attaining old age. On the one hand we have such sentiments as "Let my Lord King live forever" and "Grow old along with me, the best is vet to be". On the other hand there is Cicero admitting in the first sentence of his treatise on old age that alleviation of its discomforts is all that can be hoped "Everyone," said Talleyrand, "wants to live long but no one wants to be old." As the experts differ on this question it seems better to fall back on certain facts. In their declining years some people do enjoy life thoroughly. Even though more or less disabled physically, they may be useful and influential. It is worthwhile to search for their secret before age gets the better of us.

Unquestionably heredity plays a large part in determining longevity and in shaping the progress and direction of the aging process. While nothing can be done now to improve our ancestors, we have some responsibility in regard to those who may come after us. Infections especially if prolonged may hasten the coming of old age, but science is gradually bringing them under control.

Physical changes come inevitably with the passing of the years and they come sooner to some than to others. Many are physically old at fifty while a few are young at seventy. As a rule the mind does not grow old as quickly as the body. In the span of life a point or rather a plateau is reached where physical development has attained its highest level. Fortunately the mind may continue to increase in power long after physical decline has begun and it is common to find a vigorous intellect in an aging body.

Usually the first sign of approaching old age is seen in the skin. Its elastic fibres begin to lose some of their former elasticity; wrinkles are on the way. Then come thinning of the skin and wasting of subcutaneous tissues. The protective body surface is now more vulnerable. Pigmented areas may appear on the skin. Ancient moles may in-

crease in size. The open season for cutaneous cancer has arrived. When old age is well advanced the bones lose some of their substance, become brittle and break easily. Joints and ligaments stiffen and muscles waste. The machinery of locomotion does not work so well now. Almost as important is the slowing down of the reactions of the nervous system. Reflex action is retarded. Old age cannot meet emergencies quickly and falls a prey to the icy sidewalk, the motor car, the edge of a rug or even to the indecision of its own fears.

And so old age should have protection. But how? Certainly not by prohibitions or nagging. Many old people like to think they are independent. If they are to be curbed at all it must be done by strategy. Even then they may get real enjoyment out of living dangerously. Diplomacy will be more effective if it has a background of respect for the aged. This used to be taught in early life and possibly was carried to an extreme. Now the pendulum has swung too far in the other direction. Or is it merely that respect for age has been replaced by a spirit of comradeship? At any rate diplomacy becomes a fine art in dealing with people who are growing old but who pride themselves on their physical fitness. Such cases are often managed best by the family doctor who can emphasize the folly of - say, playing badminton after the age of fifty.

With advancing life degenerative changes occur in the cardiovascular system. In people who live by physical exertion the large arteries may stiffen and thicken fairly early. For example the radial artery at the wrist may be tortuous and hard. However, this is not serious as compared with changes in the small vessels, changes which are not necessarily the result of physical work. They may depend on the general aging process perhaps hurried on by the kind of inherited material in the vessel wall, by intercurrent infections

or by years of hypertension. Such changes are most serious in two vital centres—the brain and the heart. Hence stroke and coronary occlusion occur frequently in old people, although these arterial accidents may happen at a comparatively early period from what seems to be a local vascular disease.

The aging body is not very sensitive and is slow in revealing the existence of disease. Obviously periodic medical examinations is just as necessary here as in other periods of life. Diabetes and pernicious anemia are easily overlooked and yet as a rule they are readily controlled if discovered early. Cancer of the skin is almost invariably cured if taken in time. Old men may have chronic urinary infection and even progressive distension of the bladder for a long time before realizing that there is something seriously wrong. As a rule the aged should have all the assurance possible even when the outlook is grave. The relatives should know the truth, but the patient may be spared frank statements. Life means nothing when hope is gone and even old people generally shrink from death.

There is no particular diet for old age. It should include essentials such as raw fruit or fruit juices, greens, vegetables and milk. Changes, however, in dietetic habits should not be made without some definite reason. Certain cravings may occur in old people, for example, for salt, and should be investigated but not necessarily curbed. Usually gain in weight should be avoided. A daily walk is advisable as a general rule but it should not be long enough to tire or to cause dyspnea. A rest during the day is helpful. Old people become bed-ridden easily and even during illness may often sit in a chair for short periods with benefit. Of course a failing heart makes absolute rest imperative.

The care of the aged often presents a serious problem to the family. There may be physical or mental infirmities which make it impossible to leave them alone in the house. Elderly people may develop whims and emotionalism which make them hard to manage. They demand constant service and are not satisfied even with the most devoted attention. Only too often the burden falls on a single member of the family—generally a daughter. In assuming this burden she may serve uncomplainingly for years and give up her prospects in life. The sacrifice is too great. In many cases the parent would be just as comfortable and perhaps more contented in a home for the aged.

Search for the secret of the ideal old age takes us back to the earlier periods of life. Is there anything in prophylaxis? George Vincent once said that doctors should "train" people for old age. Perhaps he was expecting too much from the doctors. Like all teachers they may advise but people must rule their own lives and do their own training. Here are some rules.

Start at the age of accountability whenever that is. Take stock of the physical and mental capital your ancestors have given you and decide how much you can accomplish without marring or shortening your life. Avoid the yearning to do as much as somebody else who has more capital. Take the best possible care of your body. Of course you will eat moderately of the proper foods, get an adequate amount of rest and sleep, take liberal doses of the cheapest of all medicines-fresh air and sunshine, and indulge in some daily physical exercise if it is not included in your work.

There is a widespread opinion that mental overwork is a cause of early breakdown. The fact is that the mind (or brain if you like) is almost tireless if used in the right way. Specialists whether in business, in the professions or in science may become exhausted after prolonged and intensive work, but there are other mental compartments ready. It is merely a matter of turning the

key on the old interest and finding a new one. The moral is that people can overcome mental fatigue by having more than one interest. Many men when advised to retire will say, "Impossible. I would not know what to do with myself." They have gone through life on a single track and know no other. Life stops for them if there is nothing left but a siding. The bearing of this on advanced life is clear. Cultivate a diversity of interests during the active period so that something will be left to play with in old age.

All mental activity is accompanied by a feeling of either comfort or discomfort although it may be so slight as to escape notice. If it is an unpleasant feeling and rises to the level of worry, anxiety or fear, the smooth working of the mental machinery is impaired. More effort is required and fatigue comes quickly. It must be admitted that worry represents the individual's own personal reactions to his problems. Some one else might face similar problems without being unduly disturbed. This brings us dangerously close to the consideration of a philosophy of life and discretion demands a retreat. But what has this to do with old age? Just this. Like other reactions worry easily becomes a habit. If the habit is formed in the active period of life it is very likely to become accentuated in the declining years. Then the victim suffers and so does his family.

Our groping for the secret seems to have carried us to this point. The usefulness and enjoyment of old age is not affected so much by its physical disabilities as by the mental and emotional life which has preceded it. Perhaps the following prescription might be offered. In early life cultivate the virtue of equanimity. Look for the humorous side of every difficult problem. Regard life as a game to be played mostly for the benefit of others rather than as a battle for your own gain. Avoid worry as you would the plague. While you will not be able to avoid the unpleasant you should always be alive to the beauty which is all around you. And in this world of beautiful things you should find one or more interests in preparation for further pursuit in old age. As infirmities and discomforts come, treat them as lightly as possible and discuss them only with your doctor or your nurse. Either one of them can preach better than practise.

Previews

During the past few years, nurses have been called upon to assume numerous duties and to make various decisions which formerly were the responsibility of the doctor. Serious thought has seldom been given to the legality of her acceptance of this necessity which circumstance had forced upon her. The very enlightening and thought-provoking discussion of this topic by Dr. Trenholm L. Fisher focusses our attention on the legal responsibilities of the nurse, where her privileges begin and end, in the eyes of the law. Watch for the stimulating ar-

ticle "Legal Responsibilities and Frivileges" in February.

In our consideration of mental health, what thought do we give to the wellbeing of those less fortunate children whose intelligence is below normal? What assistance can be given them in making better adjustment to every-day living? Mrs. Selena Henderson has outlined some of the developments in her article "The Value of Mental Hygiene in the School" and illustrates her points with interesting case studies.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A.

The Administration and the Head Nurse

H. EVELYN MALLORY

I have just finished reading Miss Penhale's very excellent article in the October issue of *The Canadian Nurse*, and as a result, am suddenly possessed of the urge to burst into print myself! Perhaps what I have to say will be just another way of repeating the thoughts put forward by Miss Penhale — if so it will at least serve to add emphasis.

There can surely be no thinking person in the nursing world today who would not agree that no matter how excellent the classroom teaching or how good the educational program from a theoretical standpoint, the kind of nurse who is graduated from the school of nursing depends to a large extent upon the quality of her experiences in the wards and departments of the hospital. It is in the ward and at the bedside of the patient that the student nurse learns nursing. This thought has been expressed time and again at conventions, in our professional journals, and in our "off duty" conversations (Oh, very much so!). But I wonder if we have yet made the correct diagnosis or found the solution to the problem? Personally I believe that the real difficulty is expressed in one sentence of Miss Penhale's article: "An additional problem is that of giving the head nurse recognition for her work". If we could solve that problem, then I think most of the related difficulties would disappear.

In the three years that I have been associated with young graduate nurses who are preparing themselves for "teaching and supervision in schools of nursing", I have found that the great majority of them become very quickly aware of and keenly interested in the potentialities of the position of head nurse. That is the position which really appeals to them most, as undoubtedly offering the greatest challenge and presenting the greatest opportunity for satisfying work. The head nurse maintains her contact with patients, something that every true nurse enjoys, and that those of us who lose it miss greatly. The head nurse has opportunity to demonstrate administrative ability, and to be able to keep a busy ward running smoothly requires real managerial skill! The ward presents the ideal setting for teaching in that it provides opportunity to give help and guidance to students at the time when they need it in actual practice as contrasted to the artificial situation found in the classroom. Where, in the whole set-up of the school of nursing, could you find a position with greater possibilities?

As I see it, the major difficulty lies in failure to recognize and to put sufficient emphasis on the fact that the head nurse carries a dual position in the same sense that the superintendent of nurses does. It has taken us many years

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to achieve administrative recognition of the fact that the superintendent of nurses (in any hospital maintaining a school of nursing) should be as well qualified for her educational responsibilities to the school of nursing as for her administrative functions in relation to the nursing service. How many more years is it going to take to achieve a similar viewpoint in relation to the work of the head nurse? Both carry the same responsibilities, the difference being only a matter of degree, or of the area over which they have jurisdiction! The superintendent of nurses is responsible for the nursng care of all patients in the hospital, and at the same time for ensuring for every student nurse the educational experiences which she needs to prepare her for the practice of professional nursing. In like manner, the head nurse, because of the responsibility and authority delegated to her, carries responsibility for the nursing care of all patients in her unit and for providing student nurses with the educational experiences that are available there. If this latter responsibility is to be met adequately then the head nurse must have (1) preparation and (2) time for that phase of her work. Until these two essentials are fully recognized by the administration the objective of satisfactory ward teaching cannot be attained.

From an administrative standpoint, what does recognition of these two essentials actually mean? It means several things, but most important is recognition of the fact that the head nurse should have special preparation for her work. To give intellectual agreement to this statement is not sufficient. Real acceptance of the principle means that the administration will work toward the objective of employing as head nurses only those persons who have the desired qualifications. Obviously this would necessitate payment of better salaries than are paid head nurses at the present time. Ability to teach is just as essential for the head nurse as it is for the person who is going to teach in the classroom. In fact, the head nurse might almost be said to need a broader preparation, for it is she who must help the student integrate her learnings in all other subjects (Anatomy and Physiology, Bacteriology, Materia Medica, Medical Nursing, etc.) and focus them on the nursing care of the patient. If this be true then it is in the ward that we should have our very best teachers! Until those employing head nurses are prepared to insist on qualified head nurses and to pay adequate salaries to obtain them, we shall not achieve really effective learning in the ward - the only place that the student can learn to give good nursing care.

Administrative adherence to this principle means also that the head nurse should receive full recognition as an important member of the teaching staff of the school of nursing. She holds a key position when it comes to judging the effectiveness of our educational program. She sees the student (and the graduate nurse!) in action and should, therefore, be able to point out weaknesses as no one else can. Because she, of all members of the teaching staff, is the one who is in closest contact with patients, she should be able to make very worthwhile suggestions for the improvement of techniques and procedures. However, she can only meet these responsibilities in a satisfactory manner if her own education and experience have been such as to enable her to do so.

I do not believe that the clinical instructor, as we know her today, is the most effective means of meeting the need for ward teaching. That she is a very valuable person and can improve considerably the educational quality of student experiences is undoubted, but her present position should, I believe, be regarded as a temporary expedient — a "stop-gap" until such time as we are able to place as head nurse on each of our teaching wards, a person with the qualifications of our present clinical instructors. You will say that nurses so qualified are not at present available in

sufficient numbers, and I will have to agree with you — but they never will be available until there is greater demand for them! As soon as employers insist on special preparation for the position of head nurse, I am convinced that the supply will increase rapidly, for, given the opportunity to develop its potentialities, there can be no more attractive and satisfying position.

Reasons for failure to demand qualified head nurses are no doubt largely economic. Head nurses who have prepared themselves for the position through post-graduate work should, of course, be paid higher salaries than those with no special preparation, a fact that to date has not been fully recognized. But might not increased expenditure for better prepared personnel be offset by more satisfactory and efficient performance? A head nurse who understands and is able to apply effectively, sound principles of management and supervision should succeed in the long run in obtaining better results. She would know the importance of providing for satisfaction and growth of the worker and the methods to use to obtain these objectives, which should result in a greater degree of stability in the graduate nurse staff and in the sub-staff. A high turnover of personnel is never sound economy. Her understanding of what constitutes effective supervision should make possible greater efficiency, fewer errors and omissions, better nursed and, therefore, better satisfied patients. She would have a broader understanding of the objectives of nursing education and of the importance of her own contribution to it. She would know that nursing care can never be any better than our nursing education and that the ultimate aim of nursing education is ever-better care of the patient. Knowing all these things she would strive constantly to provide the student nurse with that type of experience that teaches her to focus all her knowledge and skill on the welfare of the patient. Better patient care would inevitably result. Further, and which is extremely important, the head nurse would have developed within herself and would strive to develop within her students that respect for the personality of both patient and worker (be she graduate nurse, student nurse, or ward maid) that is so essential for harmonious working relationships.

Administrative recognition of the need for qualified head nurses also implies acceptance of the fact that the teaching responsibilities of the head nurse (in any hospital that operates a school of nursing) are equally as important as the administrative responsibilities, and require equally as much time if they are to be met in a satisfactory manner. More often than not we find the head nurse so submerged by her administrative duties that she has no time at all for the important functions of supervision and teaching. Recently a group of postgraduate students reporting on observational visits to a variety of head nurse units included in their reports, statements to this effect: "So often head nurses said they had no time for teaching, but I feel that if they were really interested they could make time by delegating many of their administrative and clerical duties to the assistant, leaving themselves free to supervise and help the students at a time when such help and supervision are most needed. Another advantage of doing this would be that the increased responsibility would make the assistant's work more interesting to her."

So often we find that the cheapest article is rarely the most economical in the long run. This principle may apply to the purchase of head nurse service for our wards just as truly as it applies to the purchase of other commodities! Why not give a fair trial to the article which, though it has a greater initial cost, may give greater value and so in the long run prove most economical? Furthermore, we should never lose sight of the fact that any hopsital deciding to operate a school of nursing does by that very decision indicate acceptance

of the responsibility of providing education for its students. Education can never be cheap if it is to be of the quality necessary to meet the needs of present day society.

There is another aspect of this problem that I would like to emphasize. The field of public health nursing is an everexpanding one with tremendous attraction for the young graduate nurse of today. More and more of our nurses are being drawn into this field, and rightly so, since there is great need for their services. However, public health nursing as a specialty is built on the foundation laid by the basic course. Unless we take steps to make the field of nursing education equally as attractive as that of public health, and thereby draw into it some of our best material, the quality of the basic course is in danger of deterioration and with it the quality of nursing service in all fields.

To SUMMARIZE:

There is no more important position in the whole field of nursing than that of the head nurse, important equally to the patient, the student and the nursing profession.

There could be no more attractive

position were its potentialities fully developed.

To meet the responsibilities of her position adequately the head nurse must have:

- 1. Special preparation for her work the kind of preparation now required of the "clinical instructor".
- 2. Time for supervisory and teaching activities; time, the achievement of which is to some extent a matter of effective management.

To obtain head nurses with the necessary qualifications the administration must be prepared:

- 1. To demand special preparation for the position. Demand will increase the supply.
- 2. To improve the status and dignity of the position of head nurse by according her full recognition as an important member of the teaching staff.
- 3. To pay salaries commensurate with the preparation required and the dignity of the position.
- 4. To recognize the fact that supervisory and teaching activities take time, but that time so spent pays dividends in the form of better nursing service through better nursing education.

A Central Nurse Placement Service

Establishment of a central bureau for placement of nurses and counseling was approved by the Board of Directors of the American Nurses Association at its meeting in September, 1944, as a result of a study of Nurse Placement Service in Chicago, conducted this past year by the ANA to determine the feasibility of conducting a national central placement service.

The plan calls for close co-operation with nurses professional registries already established throughout the country. It provides for the conversion of five or six selected registries into regional demonstration centres which may serve as practice fields too, for nurses enrolled in counseling and professional guidance programs in colleges and universities.

The general plan, for which details have not yet been worked out, was presented at the conference for, Registrars of Nurses Professional Registries conducted by the American Nurses Association in St. Louis, Missouri, November 1-4, 1944.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

Changing Emphasis in Supervision in Public Health Nursing

MILDRED I. WALKER

Every nurse has experienced some form of supervision. If this were a class discussion period, the reader might be requested to give her concept of supervision, its definition, philosophy, aim, and methods of improving its effectiveness in public health nursing. On the basis of an inventory of the advantages and disadvantages of supervision as applied to her own situation, she might evaluate better the contribution made to the form of supervision prevalent through the various articles on supervision in public health nursing which have appeared on this page of the Journal today. It has been built up over the years by suggestions and conferences within organized groups. Further criticisms and suggestions will be welcomed as this will assist us to secure better supervision in public health nursing in Canada. It may also bring about more and larger conferences on supervision leading to a better co-ordination and understanding of all nursing services.

Supervision as defined in the dictionaries implies authoritative direction. It is described as the act of overseeing; inspection; superintendence; oversight. A change in meaning has developed in our use of the term as applied to supervision in public health nursing. Supervision is now considered as guidance, the

aim of which is to promote increasing growth in those supervised. To practice the principles of guidance most effectively one must be truly democratic. The entire staff must confer, participate, and share in this democratic process. Each must be encouraged and guided to contribute on her own level — emotional, intellectual, and social. Out of this the best intelligence will emerge and group action will follow.

In public health nursing, there is a high quality of interaction so there must be intelligent guidance. The former type of authoritarian, autocratic or traditional supervision is sometimes referred to as "the old school". It has become outmoded, but there are still those in the position to guide or supervise who are authoritarian or dictatorial in method. The traditional method is not acceptable in our present democratic community service where supervision includes the director who guides the administrative program, the supervisors who guide the staff, and the staff who carry public health nursing service to the family. Here, too, guidance is given to assist both the family as a unit, and the individual, to attain and maintain selfdependence and healthful living. To reach this end there must be group action of the whole staff, because the con-

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tribution of each is equally important to the smooth functioning of a well-integrated program of community service. The traditional or authoritarian process is subjective and follows the dictates of one person whereas the democratic process is objective, and is based on the contribution of the group as a whole in relation to the total situation. True, there has to be leadership, but it must be creative and purposeful, to meet the ideals of democratic thinking.

A second change is from emphasis on efficiency as such to professional growth. Emphasis on efficiency alone has a finality which does not permit growth. Life is an on going activity, a continuous process of development, that is, the process of becoming more capable, more skilled through performance. Efficiency alone implies a state which the individual may reach, a finality beyond which one does not go. It should be considered as a means to an end because efficiency plus growth, indicates the level of her professional activity according to the education and experience of the nurse. There is a rate and degree of growth peculiar to each individual. Some nurses with twenty years of experience may not have grown as much as others with five years of experience. The type of experience must be considered. One nurse who might fill a page with a list of her experiences, may not have stayed long enough anywhere to grow professionally. The professional experiences of the nurse must indicate professional growth and achievement. Each nurse must be autocritical. She must learn to evaluate her own experience, and must recognize her assets as well as the places where she needs further to lift her level of effectiveness. If she does not receive the promotion she has hoped for, she should ask herself why. It may be she is not in a democratic situation or it may be she is not contributing to the best of her ability and knowledge. Since life is a process of continuous growth, there must be some way in which she can improve, otherwise there is a feeling of finality and no further growth. Therefore, the nurse must continually appraise all the factors in her specific situation. In one's family, one is accepted as a personality, as a part of the whole; in the work group or the play group one is accepted for the contribution one makes. We possess security in the group because we belong, and we belong because we contribute. Therefore the nurse must evaluate her contribution to the group in public health nursing. Make it the best she can according to her abilities and she will find satisfaction in this achievement. The result will be more than efficiency, it will be professional growth.

The third change is from a negative emphasis on the individual and isolated personality traits to the consideration of the whole personality pattern in relation to the situation. It must be measured in terms of the level of emotional adulthood developed by the public health nurse. Personality traits must be related to performance in a variety of situations and are of no value if isolated. To report, for instance, that a nurse has had three emotional outbursts; or to say that a nurse has a pleasing personality, does not mean much unless you know the reasons for the emotional outburst, or have a basis for estimating what is meant by a pleasing personanty. Both nurses may be in an autocratic social climate where the response of the one is rebellion and the other submission. In both cases there must be a level of adult behaviour against which they can be measured. It is impossible here to outline the characteristics of adult behaviour in relation to public health nursing but a subsequent article in the Journal will attempt to do this. The aim in analyzing the total individual is to guide her in developing and maintaining a wholesome, well-integrated personality so she may give fully of her abilities in guiding others to healthful

A fourth change of emphasis is on the performance of the individual ra-

ther than on her personality. Educators realize too much emphasis has been placed on personality at the expense of performance. It is true one's personality is reflected in one's activities, but any appraisal of performance includes an estimate of the ability to perform as well as the manner in which the performance is accomplished. If the appraisal is completely objective it creates little difficulty in supervision. Though personality is an innate part of the nurse and she controls it, her ability and her work are the products to which the agency has a claim. The actual work is a more tangible thing to measure than personality. Through improvement of performance will come the sense of achievement which is so essential to the full development of a wholesome personality. In the former emphasis on personality, too often the supervisor stressed the weaknesses of the nurse rather than her strong points. The story is told of the cook who was applying for a job. The mistress said to her "Your references say you are tardy, indolent and untidy". The cook said "Is that all! Nothing about my puff pastry?" It will make supervision so much more pertinent if we point out where the nurse has been successful as well as noting where she can improve her performance. Accept what is good teaching in a home visit on nutrition, and then go on to indicate where she can improve her teaching in the next visit to that family so that she may lift her levels of effectiveness in health education. Every individual must know achievement, otherwise there will be a feeling of frustration. Continued frustration leads to disintegration of personality.

The fifth change of emphasis is from individualized effort on the part of the director or the supervisor to group action on the part of all. The supervisor guides and sets the social climate in the situation but each worker must have a feeling of belonging to the group, that she has something to contribute and that her contribution to the group is

essential. Out of coherent, well-integrated group-planning, with democratic leadership, will come performance which will be positive, uplifting and integrating. Through this process, the group and the individuals within it grow in stature. When individuals withhold their active interest, they do not grow or know the enrichment of personality, and the joy of achievement which will be reflected by the staff as a whole in their service to the family and the community. A fine example of group effort or democratic leadership was seen in the picture "Desert Victory". You will remember that the chiefs made their plans which in turn were relayed to the men and discussed down through the ranks. All felt that they were a part of the great plan; they had that feeling of belonging, as well as understanding what was to be done. It has been stated that the morale of that desert army was one of the highest in the world. If democratic leadership could prevail under such circumstances and united action result, surely it is not too much to expect in all nursing situations a democratic social climate which results from this form of leadership.

Finally, public health nurses need to be aware of changing emphasis in general education and incorporate it into their own field. Formerly, education stressed competitive living and the result was the failure of an increasing number of individuals who could not compete in the mad scramble for wealth and luxuries. It is realized now that if the future is to be free from war, we must educate for co-operative living where all, from the moron to the genius, will know the joy of achievement, in a society geared for each and everyone to make his contribution on the level where he can accomplish most. Nursing education has stressed far too much the competitive spirit, where the failures of the nurse were enlarged upon and her successes minimized. Too often students have stated that they were told where they were wrong but not

told when they had been right. The emphasis should be on picking out the satisfactory parts of any performance, and then deciding with the nurse what methods will help her to improve her performance in a future situation. A good supervisor is a good teacher. In a learning situation, nothing succeeds like success. It is difficult to build on failures as one gets resistance (not resentment) to supervision. In public health nursing it is imperative that we emphasize cooperative rather than competitive living.

In the whole changing emphasis, there must be respect for the individual with individual rights, these to be made use of so each may make the best possible contribution to society. Therefore, there must be an awareness of the changing emphases in our methods of supervision, from: (1) The traditional, autocratic or authoritarian to the democratic; (2) from efficiency as an end to growth in the nurse in relation to her work; (3) from the negative emphasis on isolated personality traits to the total personality pattern in relation to the situation; (4) from emphasis on personality alone to emphasis on performance; (5) from individualized effort on the part of the supervisor to group effort resulting in group action on the part of the whole staff; (6) and from competitive living to full co-operation.

Over-Fortification of Milk not Needed

The increasing practice of fortifying milk with vitamins other than D, and with minerals, does not serve a public health need and, by increasing production costs, can result in decreased consumption by those in the lower economic levels who need it most, the Council on Food and Nutrition of the American Medical Association declares in a recent issue of the Journal of the Association.

The Council explains, says the Journal, that it has accepted and encouraged the fortification of milk with vitamin D well beyond any natural level because of the belief that such is in the interest of public health inasmuch as vitamin D is not present in important amounts in a customary diet unless fish oils are included.

Explaining that a fortified milk had been submitted to it for acceptance, the Council says that "the question arises as to whether it is in the interest of public health to fortify milk with vitamin A thiamine, riboflavin, niacin, iron and iodine or any one of these materials".

It was explained that any deficiency of vitamin A found in the United States was at the lowest economic levels and that such

persons were not likely to buy milk sold at a premium. Milk more than carried its own load with regard to thiamine and riboflavin. The addition of niacin to milk would not seem to answer the problem of correcting any existing niacin deficiency while a diet containing meat, eggs, green vegetables and whole grain or enriched flour supplied the iron requirement.

Table salt had been selected as the appropriate iodine-carrying food and "it seems unwise to sanction the addition of iodine to more than one food", the report says.

In conclusion, it is stated that fortification of milk with vitamin A or any or all of the above-mentioned minerals "does not serve a public health need sufficiently to warrant Council acceptance of the fortified product".

-Health News Service

The New Zealand Registered Nurses Association was forced to abandon its annual conference last year because of railway travel restrictions. Travel permits there are issued to not more than ten persons to attend a meeting.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

An Epidemic on an Indian Reserve

WILMA RAYNOR

Early in Spring, after a successful fishing season along the Dauphin River, the Indian fishermen and their families climbed into their respective cabooses and started on their homeward journey. The homes of these people were on the Indian Reservations at Lake St. Martin and Fairford River. In addition to the fish, they brought back innumerable bugs, both crawling and minute unseen ones, among which was found the bacillus of typhoid.

On checking the first few reported cases of "Black Fever", as it is known to the Indians, the doctor suspected the dread disease, typhoid. These suspicions were confirmed when the first Widal reports came from Winnipeg. Immediately all known contacts were checked. A number of these patients were found sitting up in rocking chairs; others, wandering about, despite their weakened condition. Although most victims were already helpless, with a characteristic listless expression, their dark eyes seemed to appeal for help and their bronzed faces were many shades paler than usual. Like any other group of people, the Indian objects to being ordered about and frequently harbours a fear of the white man's hospital. However, the community doctor, being highly respected by all who knew him, had little difficulty in persuading the Indians to enter the improvised hospital and

in a short time it was filled to capacity. In reply to an urgent request, an extra nurse was promptly sent out from Winnipeg.

In order to provide this temporary hospital, the school at Little Saskatchewan, the centre Reserve, was closed. It was emptied of furniture with the exception of a few apple boxes which later served as bedside tables. The first patients to be admitted brought their own beds and bedding. There were a few who came without either, but were content to rest on the floor after a strenuous journey over the rocky road to Little Saskatchewan. Bunks were hurriedly built by the missionary as the need arose. In the case of a small child, the bed could be made with little trouble by putting up a hammock, Indian style,



Staff of temporary hospital at Little Saskatchewan Reserve.

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An improvised bunk in the schoolroom.

and, until cots arrived, it was necessary in some cases to double up. The Indian women who came to help as nurses brought their bedrolls and slept on the floor until beds could be provided.

The Indians were good patients but it was a task to keep them satisfied on the prescribed diet. The Indian likes to eat plenty when it is available and considerable explaining, with the help of an interpreter, was necessary to make them realize the need for restriction in diet. Well-meaning relatives quietly offered apples and cookies to the sick children whom they felt were allowed to go hungry, thus requiring constant watchfulness on the part of the nurses. The patients soon began to appreciate the comforts of a bath, clean linen and nursing care. The Indian usually retains his clothes when going to bed and if ill always puts on extra warm ones. Heavy woollen underwear and four or more pairs of socks as well as the outer garments, including hats, were removed gently and with much persuasion. Baths were accompanied by much giggling. Before many days passed, these patients were asking for baths and looking forward to dinner trays. One day a little girl appeared very sad and silent. Finally her Indian nurses' aide discovered that she had not received a serviette on her tray. This was soon remedied and the little patient ate heartily and smiled her thanks.

The women who were trained to assist with the nursing care did excellent work and performed their duties faithfully and efficiently. They became very observant regarding important signs and symptoms and reported anything unusual to the nurse-in-charge, who, in turn, dealt with all troubles and complaints. These were many and varied. Often many privileges had to be granted these women in order to retain their goodwill and service but it was well worth it. The cooking, laundry and cleaning, as well as assisting with the nursing care, was carried on by four Indian women. They worked well together and when extra duties were required they could be relied upon to lighten the work of the charge nurse and her assistant. It was a pleasure to watch them going about with quiet step, seldom hurrying but always purposeful and happy. They took great pride in their white uniforms.

Chloride of lime was used generously. Almost the entire settlement received inoculations. Twenty-two patients were treated and all made satisfactory recoveries. No new cases have developed since the closing of the hospital.

For the Mentally Ill

It should be an accepted rule that general hospitals should not be required to retain mental patients for more than 24 hours unless they have adequate detention facilities. Because of the close association of mental and somatic diseases, there is considerable

justification for the viewpoint that many temporary mental disturbances might be treated in psychiatric wards in general hospitals.

-Hospital Personnel and Facilities

Conference on Tuberculosis Nursing

During the past few years, since the supply of nurses has been seriously affected by wartime conditions, the problem of the shortage of nurses in the field of tuberculosis nursing has become increasingly apparent. The situation was emphasized in the province of Manitoba by the results of interviews conducted in August and September, 1943, with 161 general practice nurses. Of this number 112 refused to do tuberculosis nursing. An enquiry into the underlying cause of such refusals revealed two chief reasons:

- 1. In a majority of instances the nurses had had no student training in tuberculosis nursing because negative tuberculin tests had caused such experience to be withheld.
- 2. Fear of contracting the disease, either on the part of the nurses or of their relatives, was another major factor in the unwillingness of this group of nurses to undertake tuberculosis nursing.

The Board of Directors of the Manitoba Association of Registered Nurses, concerned because of the present and future need for nurses to carry on this essential service both in sanatoria and in the community, invited the Manitoba Hospital Association to assist in initiating a study of the problem by the establishment of a joint committee. It was decided by this joint committee that a conference with wide representation should be called, for the purpose of considering the question of student training in tuberculosis nursing. The conference was held in Winnipeg on April 15, 1944. Approximately sixty-five representatives were present. Dr. R. G. Ferguson, director of Medical Services and general superintendent of Fort Sanatorium, Saskatchewan, and Miss M. Diederichs, president of the Saskatchewan Registered Nurses Association, were present by special invitation. Serious consideration was given, at that time, to the following aspects of the problem:

- 1. The history of student nurse affiliation in tuberculosis nursing in Manitoba.
- 2. An estimate of the need for more and better prepared nurses in the field of tuberculosis nursing.
- 3. The relationship between a negative tuberculin test and susceptibility to infection.
- 4. A discussion of the value of B.C.G. vaccine.
- 5. The position of sanatoria with regard to the safeguarding of personnel; young graduate nurses, affiliating students, volunteers and others.
- 6. The advisability of expanding the student nurse affiliation program in tuberculosis nursing.
- Dr. H. Coppinger, medical superintendent of the Winnipeg General Hospital, opened the discussion with a report on the history of student nurse affiliation in tuberculosis nursing in Manitoba. In 1929 attention was called to the fact that sixty nurses had been admitted to sanatoria in the previous five years. As many of these were graduates of the Winnipeg General Hospital the following measures were undertaken by that hospital: annual chest plating and physical review of nurses; tuberculin skin reactions; efforts to control the technique of patients on the wards.

It was arranged that non-reactors among students should not go on duty on a tuberculosis ward. Student health records were kept for a period of ten years. During that time there were twentynine nurses who contracted tuberculosis and all were non-reactors. Dr. Coppinger stated that the problem now is to provide nursing personnel for tuberculosis sanatoria. The policy of safeguarding student nurses has made them dread the diseases, they have been edu-

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cated to believe that it is not safe, and consequently they refuse to accept positions in sanatoria. Considerable discussion followed regarding the danger to the student of contracting tuberculosis in a general hospital as compared with a sanatorium.

In an endeavour to estimate the need for more and better prepared nurses in the field of tuberculosis nursing Miss E. Russell, director, Nursing Division, Provincial Department of Health, spoke from the point of view of the need in the rural community. She pointed out that as the public health nurse should be a teacher in all her home visits she needs a knowledge of the prevention and control of tuberculosis. She should have experience in caring for tuberculosis patients, know the importance of proper diagnostic facilities, their use and availability to the people of Manitoba, and she should know how to protect the family and herself. She should be familiar with the treatment required and used, and should have worked with patients undergoing treatment in order to interpret the effect of such care to patients and families. She needs to develop attitudes at least as sound as those which patients and their families have developed.

Miss L. Kelly spoke of the needs of the urban community stressing the fact that a considerable part of tuberculosis control work and case finding is entrusted to the public health nurse as she visits the home. It was pointed out that nurses who enter the general field of bublic health do not have sufficient training in tuberculosis and little, if any, practical experience in dealing with the disease. Objectives for the effective nursing supervision of tuberculosis patients and their families were outlined, and it was suggested that the nurse who knows little about the disease is defeated before she begins because she does not have sufficient knowledge to make her talk convincing.

The City of Winnipeg Health Depart-

ment, Nursing Division, is responsible for the supervision of 1,018 families where tuberculosis is the major problem. It follows, therefore, that every member of the nursing staff must know something at least about tuberculosis as a health problem.

It was suggested that the following safeguards could be considered in planning an affiliation program with sanatoria:

- 1. Teaching of patients, supervisory and nursing personnel and others.
- 2. Rearrangement of sanatorium facilities to provide one infirmary ward where only patients with minimal, non-bacilliary disease, or with more extensive disease controlled by some form of collapse, would be cared for by the students and where they could learn in a reasonably safe environment, routines followed by patients with infectious tuberculosis.
- 3. An organized program for students and graduates, including clinics, demonstrations and lectures. Student nurses should be assigned complete case studies which should include all aspects of the patient's welfare as well as those of his immediate family and contacts.

The need in sanatoria for nurses with preparation in tuberculosis nursing was discussed by Miss E. Stocker, superintendent of nurses, Ninette Sanatorium. The opening sentence of this paper was as follows: "We find the present day sanatorium for tuberculosis is a hospital where modern and progressive scientific treatment is being carried on, but we do not, in many instances, find there nurses who have had any special preparation in the field of tuberculosis nursing prior to coming on the staff". This situation has become increasingly serious because of wartime conditions when nurses are drawn from available sources regardless of qualifications in this specialty. The result is that staff education has been neglected and too many aides in proportion to the number of registered nurses are being used to fill the needs. While the aides may give

the necessary bedside care to certain types of patients, they require supervision of their technique, particularly in protecting themselves. At the present time there is not sufficient staff to give this supervision. It was pointed out that the care of the tuberculosis patient is a nursing problem, and that the sanatoria should be prepared to give affiliating student nurses a full educational program. It was suggested that tuberculosis experience could augment the desired experience in acute communicable disease as the two departments have several objectives in common.

Dr. D. L. Scott of the Central Tuberculosis Clinic led the discussion on the relation between a negative tuberculin test and susceptibility to infection. Dr. Scott stated that there is no absolute immunity to tuberculosis, nor can resistance to the disease be measured. It is thought that resistance to an infection can be increased by a small, or several small doses of the infection, whereas a fairly large dose would cause disease. It stands to reason that people with positive reactions to tuberculin, yet who are not sick, have received a small infection and therefore their resistance should have been somewhat increased. Nonreactors have never had the benefit of this resistance-increasing dose. Dr. Scott remarked that this is purely theoretical, but that the contention is supported by a study of the nursing classes going through the Winnipeg General Hospital from 1934 to 1943.

In the ten-year period 774 girls were admitted for training. On admission 28.7 per cent reacted to tuberculin. During training 33.8 per cent became positive, 37.5 per cent remained negative. There were twenty-nine or 3.75 per cent of the total group who developed some manifestation of tuberculosis during, or shortly after finishing their course. It is notable that these twenty-nine all belonged to the negative group on admission — close to 5 per cent. None of the positive group developed the disease in any form. Surely some of the positive group were exposed to infection, and if s. I

think we must presume that their resistance on the whole was greater than the negative group.

In his opening remarks in leading the discussion regarding the value of B.C.G. vaccine, Dr. Ferguson stressed the point that those who care for the sick run the hazards of disease, and that the hazard of tuberculosis for student nurses is greater now than it was twenty years ago. At that time practically all were positive reactors, before entering training:

Any nurse who nurses until the age of thirty becomes a positive reactor, no matter where she nurses. In former days, nurses became positive before coming to the hospital; now they become positive afterwards. Nurses do contract a lot of tuberculosis, but most of them contract it in a general hospital. Two hundred nurses in Saskatchewan contracted tuberculosis during ten years, between 1934 and 1943. Of these, forty-four had contracted the disease in sanatoria, 156 had not. Therefore, general hospitals in that province are responsible to a large extent for tuberculosis among nurses.

Although negative reactors are the great problem, it was pointed out that positive reactors are not immune to tuberculosis; they are less susceptible than negative reactors. Dr. Ferguson outlined the results of the use of B.C.G. vaccine in Saskatchewan as follows: "In five years, 1,329 negative reacting nurses from eight hospitals were vaccinated. In that group, ten have developed tuberculosis, or three quarters of 1 per cent. At the same time 681 exposed persons in three sanatoria were vaccinated (nurses, nurses' assistants, and orderlies). In this period, two of that number developed tuberculosis. There were no nurses among them. Among nurses in the eight hospitals who were positive reactors on entry, ten developed tuberculosis". All of these hospitals are very much in favour of vaccination with B.C.G. vaccine, Dr. Ferguson said.

Discussing the position of sanatoria with regard to safeguarding of person-

nel, voung graduate nurses, affiliating students, volunteers and others Dr. E. L. Ross, medical superintendent, Ninette Sanatorium, outlined the history of treatment and control of tuberculosis. He spoke of the success of the antituberculosis campaign which has greatly lessened the number of infective cases at large in the community. Thirty years ago, 75 per cent of the population were infected, but now only 5, 10 or 20 per cent of the children and young adults. Dr. Ross stated that he was in favour of the use of B.C.G. vaccine, particularly for those who are engaged in caring for the sick. He pointed out, however, that B.C.G. does not provide absolute immunity, and that none of the preventive measures now carried out should be slackened. With regard to the nurse, Dr. Ross felt that she would more readily assume her true role, if those responsible for tuberculosis work would demonstrate to her that everything possible is being done to safeguard her and that possibly a more interested and intelligent appreciation of protective technique could be attained if the nurse was given an opportunity to learn more about her individual patients.

Fifteen years ago a study was made of tuberculosis in sixty nurses who had been admitted to sanatorium during the previous five years. They had all come from general hospitals. It was estimated at that time that 6 per cent of the nurses trained and graduated in Manitoba became sanatorium patients direct from their training schools or within a year of leaving them. With regard to the incidence of tuberculosis among sanatorium staff, Dr. Ross gave the following figures:

During the past six years 558 persons have been employed at Ninette Sanatorium; 223, or 40 per cent of them had a negative tuberculin test when they entered the service and 75 or 33 per cent of these negative reactors became positive. Altogether 13, or 2.3 per cent of the total number developed some evidence of tuberculosis. Of the thirteen who developed tuberculosis there was only

one graduate nurse; eight were nurses' assistants without previous hospital training, and four were maids or cleaners on wards. From this experience it would seem that the sanatorium is a safe place for the trained nurse, but less so for untrained personnel.

The 2.3 per cent incidence of tuberculosis among sanatorium personnel is lower than in nurses of a large general hospital, according to the observations of Dr. Scott, who found that over a ten-year period 3.75 per cent developed some type of tuberculosis. During the last six years at the sanatorium only one trained nurse broke down out of a total of one hundred and ten nurses employed, which is only .9 per cent. But out of fifty-eight nurses' assistants employed, 8 or 13 per cent broke down.

It is strikingly evident that more instruction and closer supervision and protective immunity is needed for untrained personnel on the wards. Finally, it is my opinion that the graduate nurse is safe in a sanatorium if she applies the knowledge she possesses and if she does not she is not safe nursing any disease.

Rev. Sister Brodeur, superintendent of nurses, St. Vital Sanatorium, continued the discussion concerning the safe-guarding of personnel in sanatoria. She stated that the shortage of nurses at the present time makes it necessary to decrease the number of occupied beds at the sanatorium in order to render sufficient service to the patients. The protective program employed is threefold: consideration of the nurses; consideration of the patient; consideration of the environment:

(1) The nurse: instruction and supervision to all new nursing personnel is given by qualified graduates. After the first week of work, the nurse is fluoroscoped and tuberculin tested. Fluoroscopies are repeated on every nurse at monthly intervals and x-rays repeated on positive reactors at least once yearly. The negative reactors are re-tested in four months, and the positive are again x-rayed. When the reaction has changed from negative to positive, the x-ray is

repeated at six-month intervals notwithstanding the regular monthly fluoroscopies.

- (2) The patient: constant instruction and supervision is carried on.
- (3) The environment: foot pedals are installed on all wash basins and personal clean towels provided. Soiled linen is placed directly from the ward into a chute to the basement, where it is collected and taken directly to the laundry. The floors are vacuum-cleaned every other day and mops when used are cleaned in a special vacuum for that purpose on each ward. Corridors are washed every day, while the floors in the rooms are washed once weekly.

During the past six years 266 nurses (including practical nurses) were employed at the St. Vital Sanatorium; 55 per cent were negative reactors. Of the negative reactors 92 per cent of those who were re-tested became positive. Of these only two nurses were negative on their third test. Of the negative reactors who became positive 17 per cent subsequently developed parenchymal lesions, 5 per cent developed pleurisy with effusion and remained well thereafter.

For the most part practical nurses are employed for general duty, and graduates are used as ward supervisors. Among the latter, only one developed parenchymal disease and she was a positive reactor at the time she entered the sanatorium. If students were accepted for affiliation the Sister stated that every nurse would be x-rayed when she began her affiliation whether her Mantoux was positive or negative, and the same would be repeated at the completion of her experience.

Dr. Ferguson congratulated Sister Brodeur on the technique outlined. He suggested the use of masks as the only other way of reducing infection.

Dr. D. McIntyre, medical superintendent of King George and King Edward Hospital, led the discussion on the advisability of expanding the student nurse affiliation program in tuberculosis nursing. He stressed the need for prepared people in the field of tuberculosis, and that the only way to prepare them was by training the student nurse. Affiliation could be made relatively safe through the use of B.C.G. and a longer period than the two weeks now given to positive reactors is needed.

Miss E. Wilson, tuberculosis consultant, Nursing Division, Provincial Department of Health, remarked upon the fact that up to the present the danger element of tuberculosis has been stressed to student nurses. The emphasis should be shifted to the fact that tuberculosis is preventable and curable.

Dr. Coppinger summarized the points brought out during the conference as follows: (1) more nurses should receive affiliation in tuberculosis nursing; (2) tuberculosis patients should have adequate care; (3) public health nurses should have adequate training in tuberculosis nursing; (4) non-reactors are the danger point; (5) Dr. Ferguson has assured us the B.C.G. vaccine is safe. The figures are convincing.

The following motion was adopted by the meeting: "That the joint committee of the Manitoba Hospital Association and the Manitoba Association of Registered Nurses undertake to call another conference to study the adoption of B.C.G. vaccine, and affiliation of student nurses in sanatoria for training in tuberculosis nursing".

It was recommended that a program of education be commenced immediately regarding the use of B.C.G. vaccine.

Compiled by

MRS. MARION E. BOTSFORD.

It would liberate many hospital beds for more acute patients and would be better for the old people if an adequate chain of institutions for the senile and those unable to work could be developed across Canada.

-Hospital Personnel and Facilities

Hospital Pests

VICTORIA ZABLOTONY and MILDRED BECKER

Editor's Note: The story of their hunt for "hospital pests" is by two preliminary students of the Royal Jubilee Hospital, Victoria, B. C.

As part of our course in hospital economics, all the students were requested to do a project in order to increase our knowledge of the subject. We chose the subject "Hospital Pests" since the study of insects was one of the important topics discussed in the class. We thought that obtaining the real specimens and studying them in their natural habitat would prove more educational than mere drawings. That's when the fun began.

Even if you suppose a place to be literally over-run with pests, when you desire to capture them, there are none in evidence. Victoria, on the other hand, turns up its nose with contempt if you suggest that such things exist within its jurisdiction. For the next three weeks we were so insect conscious that every moving dot (and sometimes stationary ones) was eagerly pounced upon. We visited fumigating centres and insulted



The mounted specimens

our friends by peering into dark corners in their houses. We even sent out an appeal to military barracks but were disappointed to learn that they are not the commonly-supposed shelters for vermin for, after much research, all they could produce was a small saw-dust flea.

The cockroach, one of our first specimens, was easily obtained as they thrive in damp warm places such as cupboards and sinks. The same was true of silverfish which flourish in basements or places where cellulose is obtainable for their food. The only difficulty encountered here was to capture the extremely active, delicate, little creature to preserve and mount it without destroying the specimen. We easily obtained a moth as these can be found in some clothes cupboards or where woollens are stored. Spiders and ants are usually found everywhere and, therefore, they gave us very little trouble. Mosquitoes presented a slight problem as they are not so plentiful in the early spring. Ordinarily flies are plentiful but again, this being early in the season, we were obliged to search more widely. Have you ever stood outside a dusty cobwebby window of an old shoe repair shop and looked longingly at a big lazy blue-bottle fly buzzing around? Well, if you have ever stood outside a milliner's window admiring an adorable hat, you will know how we felt.

Our rarest and most prized specimens were the bed bug, the pediculus and the flea. If you feel like scoffing at that statement, let us ask you, "Have you ever tried to catch them?" Despairing of finding any of these in Victoria, we air-mailed urgent messages to our friends in Vancouver and after a few weeks we received a bed bug which was obtained from a house in the slum area. Several of the neighbour's pet cats and dogs still stage a rapid retreat at our ap-

proach as a result of our ardent search for fleas. When we were almost at the point of giving up, we found one. It was a happy day when one of our instructresses brought a test tube containing a tiny pediculus corporis and nit. It was obtained from a patient and, for the sake of Victorians, we will say that he was a stranger to these parts.

As we collected we racked our brains for a satisfactory method of mounting our specimens. Test tubes were our first consideration but were soon voted down as they were too difficult to attach to the cardboard, and did not show the specimen off to advantage. The pathological department proved very helpful. One of the doctors there recommended the use of small petri dishes. He also gave us helpful hints about devitalizing our victims with ammonia or ether fumes. This aided in keeping our specimens intact.

Even then, the actual mounting was still a problem. How were we to apply these little glass saucers to flat cardboard, protect the specimen, and still have an overall neat appearance? Impossible? For awhile we thought so too. Then a ray of light seeped through. We took two sheets of the cardboard, cut holes in the top one and to it anchored the petri dishes. (We did it with adhesive tape — four small strips per petri dish). On the other sheet of cardboard (which was to be marked to correspond exactly with the first one) the

insects were mounted. We simply pasted our specimens on the bottom cardboard with clear mucilage. It wasn't quite as simple as it sounds for we spent a whole evening with tweezers and pins and delicate touch in an attempt to manoeuvre them into an effective and realistic position without damaging them. The two pieces of cardboard were then brought into conjunction. Oh! how carefully we performed this last step. One jarring move and the work of several weeks would have been undone. We fixed the two sheets together, for the last time, with a complete border of friction tape. This gave a neat finishing touch, and an appearance of compactness. With what pride we beheld the product of our labors!

We consulted books to obtain sufficient material to make an interesting and intelligible note on the source, danger and method of control as it pertained to each insect. This we printed as neatly as possible beneath the petridishes on the top cardboard.

The poster was displayed in our classroom library and was a source of great interest to all the students in the school. All in all, the catching of the insects, the ammonia and ether fumes, the sticky fingers, and the intricate work of mounting proved interesting. We have learned a great deal about the sources, dangers and control of insects and vermin that may be found in hospital and community nursing.

Scientific Progress and the Victims of the War

One very often hears it said that the ferocity of the present war is, generally speaking, the outcome of the progress made by science. Nevertheless scientific progress is beneficial, as is clearly demonstrated in that field of science where it cannot be employed for purposes other than the welfare of mankind, that is to say, the field of medical science.

An examination at the present day of the most recent scientific advances in medicine, and their effects on public health in the course of this war, leads one to wonder whether, later on, it will not be found that these advances have counter-balanced the evil effects of the war and saved more human lives than the war has destroyed. In the first place, we would emphasize the progress made in the treatment of those wounded in the war. During the war of 1914-1918 the medical services of all armies devoted attention to the necessity of getting the wounded into the hands of the surgeon at the earliest possible moment. In this war, this principle has been everywhere adopted and much more easily applied, not only in European countries, but even in armies operating in the tropics; for instance, the Australian and American medical services in the southwest Pacific have succeeded in placing the wounded in the hands of the surgeon some five or six hours after they have been hit. Medical units have also been organized — as in the Indian Army Medical Corps — which can be landed by parachute from aeroplanes.

Without going into the details of the progress made in surgical technique in wartime traumatology, there are three points of special importance which mark outstanding progress as compared with the first world war: the very early use of plaster-of-Paris splints, the enormous use made of blood transfusion, and the employment of sulphonamides.

The use of plaster-of-Paris is, of course, not a novelty; but as a result of the experiments made by Trueta, military surgeons began to resort to the use of plaster immobilization very soon after a wound had been received and this has saved many limbs which would otherwise have had to be amputated.

In this war, blood transfusion has played a part very different from that assigned to it in the war of 1914-1918. Originally employed as a means of replacing blood lost by haemorrhage, blood transfusion is now much more often resorted to in the case of shock or burns, because, as a result of the employment of new explosives and new methods of incendiary bombardment, it is much oftener required for the treatment of shock or burns than to compensate for loss of blood, and its employment for the latter purpose has become of secondary importance. Now in

cases of shock or burns it is not necessarily blood which the patient requires, but fluid to fill up his circulatory system or to make good the liquid which the organism has lost; and no liquid fulfils these requirements better than blood plasma or serum. For this reason, at the present day, the great majority of transfusions are effected not with blood, but with plasma or serum. This offers the great advantage that the limitations imposed by the incompatibilities existing between the various blood groups can be ignored and that plasma or serum can be kept practically for as long as may be desired, especially if dried. This latter possibility has, in the course of the present war, enabled transfusions to be effected not only in the front line but in the most difficult conditions: in submarines, in the heart of the jungle, etc.

Though the discovery of sulphonamides dates from before this war, it is during this war, that they have for the first time been employed on a large scale. Their efficacy against certain septic infections and particularly against those caused by streptococci is well known. Sulphonamides have been largely employed during the war, not only for the local or general treatment of infected wounds, but also as a prevention of infection. Even more than sulphonamides, another product seems destined to play a most important part in the treatment of septic war wounds; we refer to penicillin, a product derived from filtrates of a culture of the fungus Penicillium notatum discovered Fleming and subsequently perfected by Florey and numerous other investigators. This product, even when very greatly diluted, is capable of preventing the multiplication of certain microbes — including certain species of microbes against which sulphonamides are ineffective — a capacity which is known as "bacteriostatic action". Penicillin may really be regarded as a discovery of this war, for a systematic study of its properties has only been made since the outbreak of hostilities and its first surgical applications have been to war wounds. Judging from the experiments conducted by Florey in North Africa, it seems likely that penicillin will revolutionize the treatment of wounds. Thus the closing of a war wound was hitherto a grave mistake, but with penicillin it will probably be wrong not to do so.

The wounded, however, are not the only victims of war: until the beginning of this century, in every war, losses from disease exceeded those in the field of battle. During the present war, notwithstanding the grave fears felt, typhus only increased to a very moderate extent on the eastern fronts and in adjoining countries. This is to be attributed to the very strict application of prophylactic measures which have been improved more particularly as the result of the study made of anti-typhus vaccination, which at the time of the first world war had not yet acquired much practical value, but which has now been applied to whole contingents of troops, as for instance the American troops in North Africa.

Vaccination against typhoid and paratyphoid was already known in the former war, but the progress made in the immunology of the microbes responsible for these diseases has made possible the preparation of new types of vaccines which are much more effective and here again large scale experiments — for which wars often afford the opportunity — carried out in North Africa have proved that the more modern vaccines used in one camp have a greater protective value than the old vaccines which were used in another camp.

A serious intestinal infection which often assumes the proportions of an epidemic in armies at war, especially in hot countries, is bacillary dysentry: this is a malady in which the vaccines for its prevention and the serums for its cure have certainly not been so successful as had been hoped. But during this war, certain sulphonamides — such as sulphaguanidine and sulphasuccedine —

have proved most effective in its treat-

Another disease which often intensifies to such an extent that it assumes the proportions of an epidemic is malaria. During the war of 1914-1918, many countries suffered from a lack of the only drug which is effective against malaria, namely quinine. In the course of the present war, Japan having conquered all the countries where cinchona trees were or could be grown, this dearth would have been still more serious if chemists had not discovered, in the period between the two wars, drugs which, in the first place prepared in Germany, were subsequently also studied and prepared in France, Russia, Italy, England and America. We refer to the products known under the names of Atebrin, Quinacrine, Acriquine, Italquine, Mepacrine, etc. These products have a therapeutic value which, generally speaking, equals that of quinine and a prophylactic value often superior to that of the latter.

Notwithstanding the progress of hygiene, a disease which in wartime tends even at the present day to assume disquieting proportions in armies and, as a result, also among the civil population, is gonorrhea. Thanks to the use of sulphonamides, an extremely effective weapon has been found and one which, especially at the beginning of this war, had given rise to a hope that this disease would no longer constitute a problem for armies in the field. More recently these hopes have become less ambitious, but here again penicillin promises to afford the means of sterilizing cases which are refractory to sulphonamides.

While the foregoing summary shows the health of the armies is today better protected thanks to the most recent discoveries of medicine, we must not overlook the benefits conferred by these same discoveries on the population as a whole during these years of war, when the causes tending to undermine the health of civilians are always multiplied. It is obvious that air bombardments, underfeeding, overwork, the limitations imposed on personal hygiene and the curtailment of rest must increase susceptibility to disease, diminish resistance and render the population more liable to the most diverse illnesses. We know that in several countries the general mortality rate is rising and that more particularly, the death rate among children has risen, in some cases, to a very marked extent and that tuberculosis is claiming many more victims in many countries. One wonders what the conditions prevailing among such populations would have been if catastrophes on the same scale had occurred when our knowledge was still at the level of twenty years ago. To-day the new conceptions regarding diet have enabled the available food to be utilized in a more rational manner, vitamins can be synthetically produced and widely distributed in the form of tablets and in this way deficiency diseases have been prevented which otherwise would doubtless have been more widespread.

Infantile gastroenteritis, which formerly killed hundreds of thousands of children below the age of two years, has now been brought under control by the use of certain sulphonamides and the mortality rate of this disease has been reduced to about one-seventh. In addition to this there is the reduction in the rate of mortality resulting from the employment of sulphonamides in cases of pneumonia, epidemic meningitis, puerperal fever and many other diseases.

Thanks also to modern methods of purification of urban water supply, there have been no typhoid epidemics due to water, even after the most intense bombardments such as those of London in the autumn of 1940, though the water mains were damaged in thousands of places and frequently the sewers emptied their contents into the mains and thoroughly contaminated them.

The increasingly general vaccina-

tion against diphtheria has definitely proved its value during the present war. In countries where such vaccination has not been resorted to on a large scale and unfortunately one of these countries is that where diphtheria vaccination was discovered, namely France — diphtheria has greatly increased; on the other hand, when vaccination is widely employed, a very marked decrease in the morbidity curve has been observed. This is the case in England where, at the present day, about 50 per cent of the children have been vaccinated and it is believed that when 75 per cent of the children have been so vaccinated, diphtheria will have practically disappeared.

Lastly, tuberculosis, that omnipresent spectre, which, in every war, never fails to dog the footsteps of demobilized troops, and spreads among the underfed population, among prisoners-of-war and refugees awaiting repatriation. Unfortunately, no sensational discovery has recently been recorded in the therapeutics of this disease, with the exception of the technique invented by Monaldi some years before the war, namely the suction drainage of tuberculous cavities. In the case of tuberculosis the old rule still holds good—early treatment, which can only be applied as a result of early diagnosis. In this respect, however, we have the satisfaction of knowing that our equipment for the fight against tuberculosis has recently been augmented by a new technique which promises great things: I refer to miniature radiography discovered by a South American phthisiologist, Manuel de Abreu. This new technique has already, in the course of the present war, made possible the radiographic survey of the whole personnel of some armies and it is also being progressively applied for the examination of large sections of the civil population. Some Red Cross Societies have adopted it; thus the French Red Cross has employed it in the case of all repatriated prisoners. It is to be hoped

that this new weapon will enable all cases of tuberculosis to be traced in good time and that the post-war social conditions will be such that every sufferer from tuberculosis, who is thus traced,

will be able to receive adequate treatment and be cured of the disease.

Professor Dr. E. J. Pampana, Director of Health and Relief Bureau League of Red Cross Societies.

Going from the Armed Services to the School of Nursing

REHABILITATION OF MEMBERS OF THE ARMED FORCES:

The Canadian Nurses Association has been considering what special concessions should be made for women who have been serving in the Armed Services and who are desirous of entering nursing on their return to civilian life. It has been estimated that there are approximately fifteen hundred young women, many of whom have already had some training and experience along nursing lines in the Service hospitals, who have expressed a preference for nursing as their career. Some of these hold matriculation standing or high school leaving; some lack one or two subjects of such standing. At the meeting of the Executive Committee, October 27 and 28, 1944, the matter of time allowance for these young women was considered and the Committee on Nursing Education was asked to outline what credit, if any, should be given on a nurse's course for experience gained in the Services.

The following report is submitted by this committee:

RECOMMENDATIONS CONCERNING CONCESSIONS IN MATRICULATION REQUIREMENTS:

Proposals:

1. That the C.N.A. recommend that each province accept general guidance

from the report on a special matriculation program for demobilized members of the armed forces as adopted by the National Conference of Canadian Universities.

- 2. That each province decide whether it will accept this as general principle.
- 3. That each province state that preference will be given to applicants with the highest qualifications.
- 4. That the recommendation from the C. N. A. be that each province make some special allowance on the usual matriculation requirement (either one subject, or at most two), and that this allowance may be granted to a promising applicant who stands well in all other requirements such as health, intelligence, personality, and experience record.
- 5. That each province accept this reduced number of subjects, when granted, as a special matriculation for the purpose of admitting demobilized members of the armed forces. This person is considered henceforth as a matriculant by the university.
- 6. That each applicant accepted under such an arrangement be given a statement of having been accepted under this arrangement of "special matriculation" for demobilized members of the armed forces.
- 7. That the Nurse Registration authorities of each province be prepared

to accept graduate nurses who hold the statement of "special matriculation" standing and to treat them as matriculants.

Summary:

The above arrangement would place all accepted students in the category of matriculants. This arrangement for matriculation standing could be applied only for ex-service members. Hence there could be no question of interfering with regular standards for the future.

RECOMMENDATIONS CONCERNING GRANTING OF AN ALLOWANCE OF TIME ON A REGULAR COURSE IN AN APPROVED SCHOOL OF NURSING:

Proposals:

- 1. That the C. N. A. recommend that each province be prepared, as a general principle, to make some time allowance for ex-service members; this to be granted under specified conditions.
- 2. That each province decide whether it will accept this recommendation as a general principle.
- 3. That the conditions of making an allowance of time on a regular course in nursing be as follows: (a) that the

applicant meet all regular entrance requirements (including special matriculation as outlined above); (b) that the applicant's high school record give evidence of good intelligence; (c) that the applicant present an official record of training and experience in work as a nursing aide during her regular service with the armed forces; and that this experience be not less than six months of continuous experience; (d) that the method of making the allowance of time be decided by each school of nursing in order to adjust properly to the curriculum of that school. Some schools may permit the student to complete her work in a period shorter than the usual three years; other schools may keep the student for three years but treat the final months as an internship, and make payment for work done during these months, while treating the nurse as a graduate at this time. This internship indicates experience with continued instruction; (e) that the time allowance on a three year course in nursing range from three to nine months according to: (1) The quality of the applicant; (2) the record of nursing experience while in the armed forces; (3) the record of the student while in the present school of nursing.

Early Diagnosis

Stressing the importance of early diagnosis of tuberculosis, Dr. E. L. Ross, medical superintendent of the Sanatorium Board of Manitoba, in the report of this Board's activities for 1943, reveals some interesting data relative to the average duration of treatment according to the stage of disease on admission and the advantage financially of early diagnosis: minimal, 12 months; moderately advanced, 19 months; far advanced, 26 months.

Dr. Ross points out that with 24,000

deaths from tuberculosis in Canada since 1939, it is evident that this disease continues to be a real problem which is accentuated during wartime. Preventing the spread of infection is our known method of controlling the propagation of tuberculosis. It is an insidious disease and by the time it has manifested itself in a person others have become infected. Hence the necessity for intensifying our case-finding program through education, clinic and survey activities.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

Reports of Provincial Associations

The outstanding activities of the Provincial Associations of Registered Nurses during the past months are summarized for the information of members of the Canadian Nurses Association.

Alberta Association of Registered Nurses:

Clinical courses are offered in operating room technique at Holy Cross Hospital in Calgary and the Royal Alexandra Hospital, Edmonton. The course in psychiatric nursing, Provincial Mental Hospital, Ponoka, was scheduled to commence in November. A course on administration for nurse superintendents of small hospitals is to be repeated at the University of Alberta beginning January, 1945. Miss Ella M. Howard replaces Miss Jean Clark as director of publicity and student recruitment. Miss Marion Murray, B.Sc., will instruct in schools of nursing on health education. A committee has been appointed to consider the establishment of a placement bureau.

Registered Nurses' Association of British Columbia:

At the request of the R.N.A.B.C., a university extension course on techniques of counselling was organized. Twenty-three nurses enrolled and reports indicate that the course will be successful.

A study of the recently revised Registered Nurses Act and the Constitution and By-laws of the R.N.A.B.C. indicated a need for obtaining opinion from legal and education experts. The registrar of the University of British Columbia was asked for an interpretation of Clause 14 of the Act. His decision, subsequently endorsed by the Council of the R.N.A.B.C., is as follows:

It is understood that applicants already registered elsewhere who apply for registration in British Columbia are to be considered as "having substantially the same requirements for registration as prescribed by the Act" if they have met in full the Junior Matriculation requirements of the Province in which they were originally registered. This broader interpretation obviates the need for applicants to meet the subject requirement of university entrance. It affects primarily nurses who completed high school before 1936.

The Joint Study Committee on Health Insurance has embarked upon what promises to be a very instructive program.

Manitoba Association of Registered Nurses:

Through aid given by the federal grant, a provincial placement service was established in August and a determined effort made to fill the needs of hospitals and sanatoria for staff nurses. A second joint conference on the subject of student nurse affiliation in tuber-

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culosis nursing was held. The Manitoba Hospital Association and M.A.R.N. have sponsored these conferences. No definite decision was reached regarding the advisability of adopting B.C.G. vaccine by schools of nursing. It was felt that affiliation for student nurses could not be made compulsory. It was resolved: That the joint committee approach superintendents of schools of nursing and of sanatoria with regard to forming a committee to draft an affiliation program.

Following the presentation of a brief by the M.A.R.N. to the Provincial Department of Health and Public Welfare advocating the licensing and supervision of subsidiary workers, a committee was formed under the Department of Health and Public Welfare, with the Deputy Minister as convener, to draw up legislation for the licensing and examination of practical nurses. This committee has representation from the M.A.R.N., the Department of Health and Public Welfare, the medical profession and from the practical nurse group. Each member of the committee has been supplied with a copy of the Canadian Nurses Association report on Subsidiary Workers (June, 1944).

New Brunswick Association of Registered Nurses:

A very successful annual meeting was held recently. A committee was formed to consider the possibility of organizing a nurse placement bureau. A committee was also appointed to meet with the Maritime Hospital Association to study the question of the licensing and practice of the subsidiary worker.

Registered Nurses' Association of Nova Scotia:

The Public Health Section is planning to hold a refresher course in February. Miss Mary Mathewson, assistant director of Nursing Education, McGill University, will be in charge of the course.

An affiliation committee has been appointed to study the possibilities of securing affiliation for the schools of nursing with the Nova Scotia Hospital, the tuberculosis and infectious disease hospital. The nurses' placement bureau which was opened March 1 is now fully equipped and functioning. Considerable difficulty is experienced in meeting the demand for nurses for smaller hospitals. The student enrolment in all except small schools of nursing has been satisfactory.

Registered Nurses Association of Ontario:

There are now twenty organized community nursing registries in Ontario and several more centres are considering the question. A committee is studying the problem of group nursing.

A demonstration in the training of practical nurses has been carried on for the past three years, through courses offered by the R.N.A.O. with the approval of the Ontario Department of Health. The demonstration has shown satisfactory results, but it is now considered inadvisable to carry the demonstration further. A recommendation has been forwarded to the Council of Nurse Education that the Honourable the Minister of Health be approached in regard to licensing and registering nursing attendants or practical nurses.

The convener of the recruitment program visited 193 high schools in 144 centres in Ontario during the period January 5—June 15, 1944. Approximately thirty thousand students were addressed.

Registered Nurses Association of Prince Edward Island:

The activities as arranged by the Government Grant Committee are being carried out as scheduled, with some

of the various travelling instructors beginning their courses.

Registered Nurses Association of the Province of Quebec:

District associations have been organized in three of the territories outlined in the Act, which creates twelve districts of the Association. Twenty-eight nurses were awarded bursaries from the C.N.A. federal government grant fund. Further financial assistance to nurses and nursing in the Province has been provided through the Youth Training Plan; 190 student nurses and 28 high school students who will enter nursing schools next year were awarded bursaries in late August.

February 14, 1945, will be the twenty-fifth anniversary of the passing of the Nurse Registration Act in Quebec. It is anticipated that the event will be celebrated in a special way, for which an arrangement committee is being organized.

Suskatchewan Registered Nurses' Association:

Miss Grace Giles has been appointed travelling instructor. She has prepared a comprehensive program which will be reported upon from time to time. Recently a Commission has been appointed by the government in Saskatchewan to study the medical and hospital facilities in the province. It is a matter of gratification that a former president of the Association was appointed as a member of the Commission. On invitation, representatives of the Saskatchewan Registered Nurses' Association appeared before the Commission and made representations in the interest of nurses and nursing service.

One hundred and seventy-five candidates are to write at the forthcoming examinations for the registration of nurses. This is the largest number of candidates which has applied to write any one set of examinations. While a number of

schools in the province have modified their requirements to admit certain students with Grade XI standing, which is the minimum educational requirement for registration in Saskatchewan, 164 of the candidates who are to write at the forthcoming examinations have senior matriculation. On September 20, 1944, the number of nurses actively engaged in nursing in Saskatchewan was 1042.

British Civil Nursing Reserve

The Ministry of Health, through its chief nursing officer, has recently informed the Canadian Nurses Association that, in view of the developments in the war situation, the time has come when the arrangements whereby Canadian nurses are recruited for the British Civil Nursing Reserve can be brought to an end; therefore, no further applications will be considered.

Of Interest to Nursing Sisters

The National Conference of Canadian Universities reached an agreement during the past summer whereby men and women in overseas service during the period between armistice and demobilization, who wish to qualify for admission to English-speaking universities, will be granted special privileges with reference to their standing as matriculants. The Executive Committee of the Canadian Nurses Association has recommended to the provincial associations that they take under advisement the matter of accepting the same matriculation program for admission to schools of nursing as has been accepted by the universities.

We quote from the report of the National Conference of Canadian Universities (pages 47 and 51):

1. Universities will accept Junior and Senior Matriculation examinations based on approved Canadian Legion text-books provided that the standing obtained indicates ability to do university work. Certificates of standing must be presented in each subject, signed by the appropriate director of education and instructor. Final credits, however, will be withheld until the satisfactory completion of a year's work.

These privileges are granted on condition that the Director of Education of each of the three armed services undertakes to see that competent teachers are appointed and that the standards of instruction and of examination are adequately high for both Junior and Senior Matriculation.

- 2. Universities will grant admission to returned men and women on less than the full requirement, but deficiencies may have to be made up during the undergraduate course, as each university may determine. Admission cannot be granted to candidates lacking the prerequisites for the course they wish to take.
- 3. The matriculation studies are merely qualifying studies. Actual admission can be granted only so far as accommodation permits. Candidates with full matriculation will usually be given preference over those with partial matriculation. Admission may be based, not only on academic standing, but also on the candidate's whole record, including school record, service record, and aptitude tests conducted by the Personnel Selection departments of the armed services.
- 4. Subject to the limitations stated above and to the detailed regulations to follow, candidates offering the subjects specified will be admitted to any English-speaking Canadian university. But others are not necessarily excluded, and each institution is free to deal with individual cases. Therefore, a candidate not able to offer the stated subjects should seek advice from the university of his choice.

Admission requirements to faculties of nursing read as follows:

Alberta, Saskatchewan, and Toronto require Senior Matriculation. Chemsitry is an essential subject. British Columbia, Queen's and Western admit at either Junior or Senior Matriculation level. McGill (for graduate nurses only) admits on Junior Matriculation.

Publicity

From a survey made this fall of student nurse enrolment for 1944, we have reason to be pleased with the results of our student recruitment program in the past two years. The need for student nurse recruits, however, still exists in that we must endeavour to maintain the 1944 level if we are to meet the needs of post-war civilian nursing service. Very briefly, the survey shows the following totals across Canada: Probationers, 2786; first year students, 2189; total probationers and first year (which will constitute the graduating class of 1947), 5011; second year students (to graduate 1946), 3655; third year students (to graduate 1945), 3528; number graduated in 1944, 3442. Grand total of student nurses in schools of nursing in Canada: 12,194 at November 1, 1944, as against 11, 350 at December 31, 1943.

Enquiries from potential student nurses continue to pour in from all provinces in response to our numerous appeals by radio, poster, pamphlet, and other contacts. To facilitate the work of the provincial secretaries in replying, particularly to those who request information concerning more than one province, a new list of the approved schools of nursing in Canada is being prepared. This list contains pointers on "How to Choose a School of Nursing" and data on each school under the following headings:

Type of hospital; number of beds; denominations; deposit fee; approximate number of students; educational requirements; minimum entrance age; clinical experiences offered; teaching facilities available; graduate personnel for teaching and service; months in new course; months classes enter.

We were pleased to be able to announce through the public press that, at the last session of the House of Commons, a clause in the bill on national finance provides for income tax deductions for parents of student nurses. Also, a press release was sent out announcing the award of long-term bursaries for university courses.

A very interesting survey of the hobbies and interests of teen-age girls is now being done. If the returns to date are any indication of the final returns, we are going to be in possession of a mass of valuable information concerning the "thought processes" of the next generation of student nurses. It will then be up to us in our guidance counselling to place our appeals "on the beam" if we expect them to be "received" by our potential recruits. Further announcement concerning this survey will be made when the analysis is completed.

Prints of the Canadian Nurses Association news-clip "White Sentries Guard Vital Outposts" have been made for use in each of the provinces. A life-size figure of a nurse which is also a theatre display card will soon be appearing in the towns and cities across Canada. Our "nurse" is also a pamphlet distributor.

Those concerned with student recruitment have felt that a goodly number of our potential student nurses have been diverted to the more remunerative and perhaps more attractive fields of war industry. Many of these workers have the qualifications that we consider essential for a nurse, and the C.N.A. has taken the initiative in providing personnel counsellors in the Canadian war industries with rercuitment pamphlets and posters, to assist them in directing or counselling the discharged personnel who could qualify towards the nursing profession.

Immunization Virtually Eliminates Tetanus in Armed Forces

Tetanus has been virtually eliminated from our armed forces as a result of compulsory immunization. Major General Norman T. Kirk, U.S.A., Surgeon General of the Army, says that not a single case has been reported among completely vaccinated troops and there has been only a handful of cases throughout the entire Army. These occurred prior to vaccination or before the immunization process had been completed. The Navy, which also requires tetanus immunization process, has had no cases of the disease among sailors or Marines wounded in combat up to September 15, 1944, according to the Navy Bureau of Medicine and Surgery.

The most recent account illustrating the value of tetanus immunization was given in the report of a Navy medical officer who served aboard a hospital ship in which 284 Japanese and 384 Americans, all wounded in the same engagement, were being treated.

Fourteen cases of tetanus, ten of which were fatal, occurred among the Japanese. None of the Americans developed the disease. Army medical records indicate that the Japanese do not immunize actively against tetanus.

Office of the Surgeon General Technical Information Division Washington, D. C.

From the Australasian Nurses' Journal we note that a new schedule of remuneration and hours of work for private nurses has been approved: fees increased to £5. 5s. a week; that there be a six-day week with a ten-hour day; that an extra fee be charged for each additional patient up to a maximum of three, an extra nurse to be engaged if there is a larger number; travelling expenses to be paid.

Interesting People

Janet Neilson, pioneer public health nurse for the City of Toronto, was guest of honour of the Public Health Nurses' Association recently at a testimonial dinner when two hundred active and retired public health nurses and friends gathered to pay tribute to her thirtyseven years of service to the community.

Appointed as nurse for the first chest clinic in 1907, during the first four years Miss Neilson worked alone and with tuberculosis only. Her district was the entire city and part of the county. Under Dr. C. J. Hastings, the work of the Department of Health expanded rapidly and in 1914 Miss Neilson became a district superintendent, which position she held until her retirement in October 1944.

Miss Neilson has many tales to tell of her work during the early years. A fire having occurred at the sanatorium, many of the patients had to be removed to their homes. Among them was Sam, living in one of Toronto's poorest districts. He was so very ill that Miss Neilson felt obliged to remain with him each night from seven to twelve so that his wife could get some rest. Precisely



A. D. Skilling JANET NEILSON

at midnight, she heard the whistle of the policeman on the beat who had come to conduct her to the street-car. She also says that she wore a bonnet, brought to her from England by the late Miss Mary Agnes Snively, who insisted that Miss Neilson wear it on her night rounds.

The following illuminated address was presented to Miss Neilson in appreciation from the people of Toronto:

The Council of the Corporation of the City of Toronto issues this testimonial in grateful acknowledgment of your thirty-seven years of consistently meritorious service as a public health nurse in and for this municipality.

Appointed in October 1907, by the late Dr. Charles Sheard, then Medical Officer of Health, you served first at the tuberculosis clinic of the Toronto General Hospital. Among your multitudinous duties was home visiting often entailing considerable bedside nursing, extending not infrequently well into the night hours, and occasionally, all night. The number of those whom you have served is legion; they are those who, if they knew, would join with grateful hearts in the eulogy.

The profession of nursing has been described as having two sides, one of devotion and service, the other of science well applied. You have been a living exemplar of both, worthy of emulation in the highest sense. You have endeavoured through the imparting of your knowledge and, as needful, the application of your skill, to bring healthful living and an appreciation of its value to all with whom you came into contact, professionally or socially. Infancy and age alike have come within your ministry, the lowly and those of high estate. Incentive enough that they suffered or were borne down with problems or doubts and needed the care and advice that you were so competent to give. By your skill, your gentleness, your sympathetic understanding and your almost religious devotion to your sense of duty, you have brought light into dark places and have in truth rightfully earned that greatest of all eulogies — Well done, thou good and faithful servant.

Miss Neilson has led a full life and has many rich memories. Now she will be able to rest and enjoy her garden, of which she is so passionately fond and in which she is somewhat of an expert. She plans, too, to do some volunteer work for a social agency. She hopes that it will be home visiting for she loves humanity even better than her garden.

Ella Mae Howard has been appointed provincial publicity director with the Alberta Association of Registered Nurses. Miss Howard not only carries on an active recruitment for nursing program among high school students and groups of women in the armed services, but also is emphasizing the importance of graduate nurses preparing themselves for positions of responsibility in hospitals and public health organizations. She works in close conjunction with Marion Murray, B.Sc. of the Holden Health Unit who has been loaned to the Association for a short time to act as instructor in health in the schools of nursing.

Gladys Josephine Sharpe, director of nurses, Toronto Western Hospital, is receiving many congratulatory messages — American, South African and Canadian — on her receipt of the Royal Red Cross, requested of the King by the South African Government, for her work as liaison officer at South Africa Military Nursing Service Headquarters, and on behalf of all nurses sent to the Union on military duty from Canada.

The citation reads, "and in your executive capacity as Matron of the Military Hospital, where you displayed great qualities of tact and resourcefulness in handling the many problems inseparable from employing nurses with such diverse backgrounds as Canadian and South African".

Helena Reimer, who has recently proceeded overseas with UNRRA, was head of the clinical teaching department at the



ELLA M. HOWARD

Winnipeg General Hospital prior to her departure. One of those well-qualified nurses who has taught school prior to entering upon her nursing career, Miss Reimer graduated from the Winnipeg General Hospital in 1937. Following graduation, she remained at her home school as head nurse and medical supervisor. In 1942 she took the course in hospital administration at the McGill University School for Graduate Nurses.

Elsie M. Tulloch has resigned as superintendent of the Carleton County L. P.



HELENA REIMER

Fisher Memorial Hospital in Woodstock, N.B., after eighteen years of service. In accepting her resignation the Board of Trustees paid tribute to the many years of faithful service. given to the institution.

Requirements of a Nurse, 1730 A.D.

Editor's Note: The following is an extract from part two "Of the Small-Pox" in Thomas Fuller's "Exanthematologia: or, an attempt to give a rational account of the eruptive fevers," London, C. Rivington, 1730, pp. 208-9; no. 2691 in the Osler Library:

Though it is impossible to meet with a nurse every way so qualify'd for the business, as to have no faults or failings, yet the more she cometh up to the following particulars, the more she is to be liked. It is therefore desirable that she be:

- 1. Of a middle age, fit and able to go through with the necessary fatigue of her undertaking.
- 2. Healthy, especially free from vapours, and cough.
- 3. A good watcher, that can hold sitting up the whole course of the sickness.
- 4. Quick of hearing, and always ready at the first call.
- 5. Quiet and still, so as to talk low, and but little, and tread softly.

- 6. Of good sight, to observe the pocks, their colour, manner and growth, and all alterations that may happen.
- 7. Handy to do everything the best way, without blundering and noise.
- 8. Nimble and quick a going, coming, and doing everything.
- 9. Cleanly, to make all the dresseth acceptable.
- 10. Well-tempered, to humour, and please the sick as much as she can.
- 11. Cheerful and pleasant; to make the best of everything, without being at any time cross, melancholy, or timorous.
- 12. Constantly careful, and diligent by night and by day.
- 13. Sober and temperate; not given to gluttony, drinking or smoking.
- 14. Observant to follow the physician's orders duly; and not be so conceited of her own skill, as to give her own medicines privately.
- 15. To have no children, or others to come much after her.

The Clinical Use of Penicillin

Penicillin succeeds in some infectious diseases where the sulfonamides would fail. It fails in certain diseases where the sulfonamides can be expected to succeed. It is capable of succeeding in a large number of diseases where the sulfa drugs would also succeed. It is essential, therefore, to know in what diseases penicillin should always be regarded as first choice; in what diseases the less costly and more easily administered sulfonamides should be tried first, with the

idea of resorting to penicillin if they fail; and in what diseases the sulfa drugs are first choice, with no probability that penicillin would be of any benefit. It is not possible as yet to give complete and final answers to all these questions.

Up to the present, penicillin has shown no effectiveness in the treatment of tularemia or of diseases due to E. coli, H. influenza, B. proteus, typhoid and paratyphoid bacilli, dysentery bacilli, B. pyocyaneus, Br. melitensis, and Fried-

lander's bacillus. Against some of these organisms the sulfonamides are significantly effective. E. coli, for example, is highly susceptible to sulfathiazole or sulfadiazine. It is not only not susceptible to penicillin; it even appears to elaborate an enzyme which inactivates this drug. This eliminates at once as indications for penicillin therapy a large number of urinary tract and gastro-intestinal infections, such as appendicitis with perforation, certain cases of liver abscess, and a large number of infections of the urinary tract. Penicillin has so far been ineffective in tuberculosis, acute rheumatic fever, infectious mononucleosis, pemphigus, ulcerative colitis, malaria, poliomyelitis, blastomycosis, moniliasis, and other diseases.

Based on the investigations of the committee headed by Keefer, penicillin appears to be more effective than the sulfonamides in the following diseases:

1. All staphylococcic infections with or without bacteremia, such as, carbuncles—soft tissue infections; acute osteo-

myelitis; wound infections; meningitis; cavernous or lateral sinus thrombosis; pneumonia — empyema; carbuncle of kidney.

- 2. All hemolytic streptococcic infections with bacteremia and all serious local streptococcic infections, such as, cellulitis; mastoiditis with intracranial complications, i.e., meningitis, sinus thrombosis, etc.; pneumonia and empyema; puerperal sepsis; peritonitis due to streptococci.
- 3. All pneumococcic infections of the meninges; pleura; endocardium; all cases of sulfonamide-resistant pneumococcic pneumonia.
- 4. All cases of clostridia infections, such as, gas gangrene; malignant edema.
- 5. All anaerobic streptococcic infections, such as puerperal sepsis.
- 6. All cases of sulfonamide-resistant gonorrhea and all gonococcal infections complicated by arthritis; ophthalmia; endocarditis; peritonitis; epididymitis. Physician's Bullletin (published by Eli Lilly and Company)

Educational Aid for Nurses in U.S.A.

Generous allowance for continuing their education, by enrolling in advanced or special programs of study, is provided veteran nurses of this war under the G. I. Bill of Rights.

Not only does the Bill provide for refresher or retraining courses for a period of one year, but also for an additional period of education or training, covering a maximum of three years.

The nurse has free choice of courses. She must, however, take them at an approved educational or training institution. The cost of tuition, laboratory, library, health, infirmary and other similar fees are provided for by the Bill, in addition to payment for books, supplies, equipment and other necessary expenses exclusive of living expenses and travel. "In no event" however, "shall such payments with respect to any person exceed \$500 for the ordinary school year".

While taking a course as provided for in the G.I. Bill, a nurse may be paid a subsistence allowance of \$50 per month if without dependents, or \$75 per month if she has one or more dependents. No deduction will be made for regular holidays or for vacation not exceeding thirty days in a calendar year. An adjustment may be made in the amount allowed for subsistence, however, if the nurse is gainfully employed while taking the course. Application for aid should be made to the Administrator of Veterans' Affairs in the the area in which the nurse may be.

If a nurse is discharged from the Army or Navy Nurse Corps for disability, she is eligible for vocational rehabilitation under the G. I. Bill of Rights. Application should be made to the nearest Veterans' Administration Facility.

- Exchange.

STUDENT NURSES PAGE

The Battle of the Bath

Josephine A. Skelton

Student Nurse

School of Nursing, Toronto Western Hospital

He bristled with belligerence. "What are you going to do?" Somewhat startled at such a direct approach I looked up from my struggles with a screen and met the suspicious gaze of my patient — a boy about twelve years of age. "A bed bath", I answered, being equally as direct. "Oh, no you don't-no you don't." Suspicion ripened into definite apprehension. "Nurse, SHE isn't going to bath me, is she?" The "she" was spoken in capital letters. A senior student, busy at the next bed, looked around the screen and remarked mildly, "Well, Billy, it looks as though she is." "No, I won't let her." He was vehement on the subject. "If I have to be bathed, I want you to bath me." "Why don't you want her to bath you?" "She's too small", he muttered after considering the matter. "I'll bet she couldn't even reach across the bed. I'm not going to let her bath me."

I nobly restrained the impulse to say "I have bathed larger patients than you, my son," and began to loosen the top bedding. "No, you don't." He was instantly alert and clutched the sheet determinedly. "What are you doing now?" "Why," I managed a fairly good look of innocent surprise, "just stripping the bed." He relaxed again. "Well, I guess you can go ahead, but you're not going to bath me, remember." Obeying his cautious permission I

finished preparing the bed for the actual bath, following the routine mechanically while my mind was busy with the problem confronting me. How could I change his truculent attitude toward me? This, I realized, was certainly a time to apply provided.

time to apply psychology.

For centuries the delicate mechanism of the human brain—what we think, what we feel, what we do and why we do it—has presented a problem which has fascinated the scientists of every age, though this study has itself become a science only in recent times. The value of psychology in medicine has become increasingly apparent in its development from the "bedside manner" of the traditional family doctor to its present position in the studies of medical men and nurses. It is not strictly true that doctors are concerned with the science and nurses with the act of medicine exclusively, for these two fields meet on the common ground of applied psychology. Whether entirely natural or acquired, kindliness, quick sympathy and tacit understanding must be employed by both doctor and nurse if the patient is to have confidence in them and in himself. To assure this, the co-operation of all these is essential.

Co-operation! This, I realized, was what I must win from my patient. The question still remained, how was I to go about it? What approach would ap-

peal most to a boy's mind? I could go ahead grimly, but my work would then be performed under difficulties which would probably be accompanied by loud and resentful remarks of a disagreeable nature. I could be quiet and rigidly dignified seeking to subdue him, and thus win a passive acceptance of the bath. The last idea which suggested itself was the possibility of sacrificing dignity to some extent by blending it with the friendliness and informal spirit of camaraderie dear to the hearts of all young boys. There would have to be an answer for his every sally. Above all, I must not allow this young patient, whose name, by the way was unpronounceable, to upset me. "No, you don't." He eyed the wash-cloth to which I was now applying soap. "I told you I wasn't going to let you bath me. She isn't, is she nurse?" The nurse at the next bed turned and looked at us. Behind her mask I could see that she was thoroughly enjoying the situation, and the laughable side of it, which suddenly struck me, gave me courage.

With deceptive sweetness which I knew would not hoodwink the boy for one second, I bent over the bed and murmured, "What is your name again? I can't keep on calling you 'little boy' ". "Billy," he answered, then realizing the insult of my words, "and what do you mean 'little boy' "? "Well, you don't look any older than my little brother". "Aw, I'll bet you haven't got any brother at all". "On the contrary, I have five of them." I tried to keep my tone at the happy medium of pleasant jeering and faint boasting which would indicate my good intentions. "Five brothers." He thought for a moment. "Five brothers, well, I guess you might as well bath me."

It was almost too good to be true. I applied the wash-cloth to his face quick ly without stopping to determine how my five brothers had influenced his decision. On the whole, the bath was fairly peaceful with no major engagements in differences of opinions, though his

questions were many and varied and my answers were not always entirely satisfactory. Half-way through the bath he sat up and indicating a few, scattered, red marks on his ankle asked what they could be. My inspiring remark was to ask the doctor.

His eyes widened. "How do you think he could cure things on legs? With medicine"? "Amputation of the leg," I said struggling to keep serious, "at the shoulder." He looked anxiously at my preternaturally solemn face. Slowly he began to smile. "All right, nurse, I'll be good. What do we do next?"

Perhaps I really had employed the right psychology, perhaps it was only luck, but at any rate the battle was over. From some hidden recess of my subconscious mind one single, unrelated line of poetry filtered through, "The citadel is taken, and the fortress attained."

Ration Test Concluded

The most extensive controlled ration test ever conducted using U. S. military personnel has just been concluded with highly satisfactory results. Major William Beane, M.C., of the Armored Medical Research Laboratory, Fort Knox, Ky., directed the test in co-operation with Major James Robinson, Inf., and Captain David Bell, of the R.C.A.M.C. American and Canadian expeditionary rations were used.

A battalion of American soldiers on manoeuvres at an altitude of 8850 feet above sea level in Colorado were fed exclusively on American ration C,K, 10 in 1, and Canadian mess tin B ration for a period of sixty days. During this time they were engaged in vigorous combat training.

At the conclusion of the test it was found that the troops were in better physical condition than at the start, with high morale. The rations were proven to be wholly adequate to sustain troops in vigorous combat. Certain items in the rations, however, were found to be less acceptable to the men than others, and these will be improved.

Office of the Surgeon General Technical Information Division Washington, D. C.

Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

The following nurses have been appointed temporarily to the Toronto staff: Constance Collins (Royal Victoria Hospital, Barrie, Ont.); Donna Cowan (Brantford General Hospital); Mary Firth, Grace Sylvester, and Vera Marshall (Toronto General Hospital); Ida Goodchild (Buffalo General Hospital, N.Y.); Una Long (Brandon General Hospital, Man.); Dorothy Pope (Hospital for Sick Children, Toronto); Blanche MacDougall (Women's College Hospital Toronto).

Jacqueline Blanchard (St. Joseph Hospital, Lachine, P.Q. and public health nursing course, University of Montreal) has been appointed to the Ste. Anne de Bellevue staff.

Verna Ryckman (Brooklyn Hospital Training School for Nurses) has been appointed temporarily to the Guelph staff.

Doris May Campbell, having been granted a Victorian Order scholarship, is on leave of absence from the Toronto staff to take the course in public health nursing at the University of Toronto School of Nursing.

Glenna Downey, Mary Elizabeth Kerswill, and Florence Sinclair, are on leave of absence from the Toronto staff to take the public health nursing course at the University of Toronto School of Nursing.

Fannie Cross has resigned from the Chatham staff.

Lucienne Boulanger has resigned from the Lachine staff to accept a position with the Department of Health in Montreal.

Emily Morrison has resigned from the Guelph staff to join her husband who has returned from overseas.

Ella Johnston has resigned from the Timmins staff.

Arminal Hay has been transferred from the Brantford staff to the Trenton staff.

Saskatchewan Public Health Nursing Service

One feature of the in-service staff education of nurses of the Department of Public Health is the bi-annual refresher course and conference. The autumn conference was held at the Legislative Building, November 27-28. The nurses were welcomed on behalf of the Department by Dr. C. F. W. Hames, Acting Deputy Minister.

Several nurses outlined special activities which they had introduced with success into their work in the districts. Those taking part in the program were: D. M. Hopkins, Regina; M. P. Edwards, Weyburn; L. McColl,

North Battleford; M. S. Langstaff, Yorkton. The remainder of the time was devoted entirely to discussions of procedures and problems related to the work of the nurse in the district.

M. E. Pierce, formerly on the staff of the Division of Public Health Nursing, has been appointed epidemiologist with the Division of Venereal Disease Control.

D. M. Hopkins, Regina, has been appointed field supervisor in the Division of Public Health Nursing.

Ontario Public Health Nursing Service

Lillie Wark (Toronto General Hospital and University of Toronto public health nursing course) has accepted an appointment with the City of Toronto Department of Health. Until recently she has been a Nursing Sister overseas with the R.C.A.M.C.

Winnifred Walker (Toronto Western Hospital and University of Toronto public health nursing course) has resigned her position as public health nurse at Milton, Acton and Georgetown and has accepted the appointment of supervisor with the Guelph Board of Health.

Nancy Carroll (University of Toronto School of Nursing diploma course) has been appointed public health nurse for the town of Brampton.

Anna Oram (Toronto General Hospital and University of Toronto public health nursing course) has resigned her position with the Board of Health, Welland, because of ill health.

Helen Elliott (Hamilton General Hospital and University of Toronto public health nursing course) has left Cochrane to join the staff of the new Kirkland-Larder Lake Health Unit with headquarters at Kirkland Lake.

Lois Kelly (Washington Sanatorium and Hospital, Maryland, and University of Toronto public health nursing course), formerly assistant director, public health nursing, Winnipeg Department of Health, has accepted the appointment of public health nursing supervisor in the Porcupine Health Unit with headquarters at Timmins.

Gene Clark (Hospital for Sick Children and University of Toronto public health nursing course) has accepted the appointment of supervisor with the Peterborough Board of Health and resigned her position at Paris.

Mrs. Alice LaRush (Hospital for Sick Children and Department of Education course for school nursing), who has been on the staff of York Township Department of Health for many years has retired.

Isabel Black, provincial field supervisor for Northern Ontario, has recently attended "A Special Work Shop Course for Trainers of Teachers and Supervisors of Nursing in Nursing Schools, Hospitals and Other Community Agencies" at Teachers College, Columbia University.

Personnel Administration

"True efficiency can be attained only as men are stimulated and grow in accord with their potentialities".

Applied to nursing, this principle which is developed in *Characteristics of Democratic Administration* in the November 1944 issue of the *American Journal of Nursing* will not only ennoble human life but will result in a job better done.

"No student of human behaviour can fail to realize", the article points out, "that the service rendered to society by nurses who are alive, alert, co-operating as a significant and valued part of the institution which they help to compose, far surpasses the service which might be expected from disgruntled nurses or from those who blindly follow orders and decisions in which they have had no voice".

Ten characteristics of democratic administration are presented "as a synthesis of some experiences and thinking":

1. Human development of all related to the enterprise is a purpose common to all enterprises and democratic administration holds this purpose to the forefront.

- 2. Responsibilities for the planning and execution of the program are fixed; they are fixed in such manner that the principle of human development is not violated.
- 3. Rules and tegulations are simple, adequate, and in written form, and are developed under the leadership of the administrator in co-operation with those who are governed by them.
- 4. Responsibilities are delegated in democratic administration.
- 5. The people have final responsibility for the determination of purposes and the broad policies to be followed.
- The expert is recognized and properly used.
- 7. A democratic temper pervades the atmosphere.
- 8. Adequate, easily accessible records are kept and comprehensive evaluation is carried on co-operatively and continuously.
- 9. Desirable adaptation and modification are constantly sought.
- 10. Limitations are recognized and frustrations avoided.
 - -The Nursing Information Bureau.

R.C.A.M.C. Nursing Service

A conference, attended by all District Principal and Senior Matrons from across Canada, was held at the end of November at N.D.H.Q.

Lt.-Col. A. C. Neill, R.R.C., Matron-in-Chief, Canadian Military Headquarters, recently arrived in Canada on a liaison visit.

Lieut. (N/S) Atala Coulombe has returned to Canada to be Senior Matron of Military District No. 5, Quebec, and will be promoted to the rank of A/Captain (A/Matron).

Lieut. (N/S) Marguerite McLean, A.R. R.C. (Newport Hospital, Rhode Island, 1915) has been promoted to the rank of A/Captain (A/Matron) to be Matron of

No. 6 Sub-section, Embarkation Transit Unit.

Lieut. (N/S) E. Pearl Atcheson (Kingston General Hospital, 1932) has been appointed Assistant to the Matron at Debert Military Hospital, and promoted to the rank of A/Captain (A/Matron).

Lieut. (N/S) Ethel May Lowe (Ross Memorial Hospital, Lindsay, 1933) has been appointed Assistant Matron at Rideau Military Hospital.

Lieut. (N/S) Mary R. Upward (Guelph General Hospital, 1937) has been promoted to the rank of A/Captain (A/Matron) and will be in charge of the operating room at Camp Borden Military Hospital.

Book Reviews

Canada's Chapel of Remembrance, by Charlotte E. Whitton, C.B.E. and Ella M. Thorburn, O.B.E. 64 pages. Published by Thorburn and Abbott Ltd., 115 Sparks Street, Ottawa, Ont. 1944. Price 50 cents.

Believing that the Memorial Chamber in the Peace Tower of the Parliament Buildings is, in fact or in spirit, the private chapel of proud and sorrowing memory for hundreds of thousands of Canada's bereaved in two wars, the authors of this booklet have sought to make available this little "vade mecum" for the pilgrim who would reinforce imagination or memory with the details of the Chamber's concept and structure.

Beautifully illustrated, with clear-cut photographs which show the detail of the various sections of the chapel with great distinctness, the accompanying legend explains the significance of each of the pictorial panels. For those who have had the opportunity of visiting the Chapel of Remembrance, this book will serve to refresh the memory of the austere beauty of the surroundings of the Altar on which reposes the book containing the names of "our nation's dead, who, in the three wars of this century, have rendered up their youth in far-off lands in witness

to their faithfulness to the ideals of their own".

For those who dwell at such a distance from Ottawa that the opportunity of actually visiting the Chamber may be lacking or infrequent, it will show with simplicity and clarity, the Memorial which Canada has consecrated.

Nursing for Community Health, by Theda L. Waterman, R.N., B.S., C.P.H. 310 pages. Published by the F. A. Davis Company, Philadelphia. Canadian agents: The Ryerson Press, 299 Queen St. W., Toronto 2, 1944. Price \$4.40.

Ever since the course in Community Health and Social Needs was incorporated into the approved curriculum of the schools of nursing in Canada, a search has been made by the instructors for suitable text-books on the student nurse level to supplement their lectures. Miss Waterman has provided a valuable addition to the list. She states in her preface, "The sooner students begin to think of their patients as people rather than as cases, the more likely they are to acquire the public health point of view".

Following an outline of the history



The Fetus, the Mother and Protein -

Numerous medical reports continue to stress the importance of adequate protein in the diet of the

pregnant woman.

Recently Burke* and her associates have shown the importance of protein intake in the mother's diet during pregnancy, concluding that "from this study it would appear that from the standpoint of birth length, birth weight and general physical well-being of the infant at birth, the diet should be liberally supplied with protein during pregnancy."

To encourage the necessary increased intake of easily assimilable protein without the burden of excessive solid food, discerning clinicians

suggest-

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Whether prepared with milk or water. Horlick's offers a palatable means of augmenting the supply of protein in the diet.

*Burke, B.S., Harding, V.V. and Stuart, H.C.: Nutrition Studies During Pregnancy, Jl. Ped. 23: 506-515 (Nov.) 1943.

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of the development of a public health consciousness, the author indicates the significance of various medical and surgical conditions, such as heart disease, cancer, fractures and various orthopedic conditions. The community aspects of the communicable diseases, including syphilis, gonorrhea and tuberculosis are carefully studied as are also the problems of maternity, and infant and child health. A chapter is devoted to the opportunities to be found for the instruction so necessary to produce better habits of nutrition. Mental health, the practical application of the things the student has learned in her courses in psychology, is included. Her own importance as a teacher is stressed.

Following each chapter there is a series of questions for further study and an extensive reading list. The text is splendidly illustrated with both diagrams and photographs which greatly enhance its value. As is natural, all the statistics and agency references are American yet they can serve as a guide to the instructor of the type of information about the Canadian scene which she should secure in order to make her lecture periods worthwhile.

Foster Home Care for Mental Patients, by Hester B. Crutcher. 199 pages. Published by The Commonwealth Fund, 41 East 57th St., New York 22. 1944. Price \$2.00.

The utilization of foster homes is a well-known practice throughout Canada for neglected children, for chronic or convalescent patients, but their use for mental patients has not been developed on any appreciable scale. Miss Crutcher's description of the plan which is working successfully in New York State opens up previously unexplored possibilities. This book will be of considerable interest to the nursing staffs of our mental hospitals as well as to public health nurses who, in some instances, might be called upon to assist the social workers in the supervision of these patients after they have been placed.

Miss Crutcher, who is director of social work, State of New York Department of Mental Hygiene, states the case for the development of these foster homes very clearly. "The deleterious effects of prolonged hospitalization on the individual personality have become more and more evident in recent years . . . Institutional life tends to reduce at best to passive indolence and at worst to bitterness and rebellion".

Foster family care is planned for those patients who are not well enough to return home or to earn their own living. Careful selection of the right type of home with kindly, intelligent caretakers is essential and a chapter is devoted to the description of the type of home that is desired. Since, in the hospital, the environment is limited largely to the small group on the ward, the patient has to learn to adjust to the relative freedom of a private home. "The majority make good adjustment and some who seemed at a standstill in the institution show definite improvement." The patients "profit from the individual attention which comes with family life".

Supervision by psychiatric social workers is provided on the basis of approximately sixty cases per worker. The total weekly cost in New York is estimated at \$6.95 per patient as against the average of \$14 per week in the mental hospital. On the grounds of economy, also, therefore, it seems a desirable plan. Miss Crutcher discusses the reasons why the plan has not been more widely put into effect and outlines a series of case histories to show the results which have been obtained.

The Baby Manual, by Herman N. Bundensen, M.D. 573 pages. Published by Simon & Schuster, Inc., 1230 Sixth Ave., New York City 20. Price \$3.50. Reviewed by Harriette S. Wilson, Public Health Nurse, Kitchener, Ont.

While this manual is primarily addressed to mothers many public health nurses will find it almost as valuable as a refresher course. The foreword by Thomas Parran, M.D., Surgeon-General United States Public Health Service, is interesting and refreshing. It explains that the book is based on the experiences of Dr. Bundensen during twenty years, and is "the quintessence of the wisdom of our country's leading obstetricians and pediatricians".

ANTISEPSIS

The testimony of the medical press

The first paper on 'Dettol' was published in 1933.* It dealt with only one property of this new antiseptic - its bactericidal power against hæmolytic streptococci; and only one application of this property - the prevention of puerperal infections. In this paper, 'Dettol', on the basis of an investigation at London's great maternity hospital, Queen Charlotte's, was described as more effective than any antiseptic hitherto used in obstetric practice. Within a few months of its adoption as the routine antiseptic, the incidence of maternal infections had fallen by over 50 per cent.

Many confirmatory papers followed, and in a few years it became evident that the uses of 'Dettol' were virtually co-extensive with the whole field of antisepsis. Clinical and laboratory investigations alike attested to the dependability of 'Dettol' in all the contingencies of practice — surgical, medical and obstetric — that called for an antiseptic combining effective bactericidal activity with gentleness to sensitive and wounded tissues, even at full strength.

'Dettol' applied to the patient's skin has been found to confer immunity to reinfection by Strep. pyogenes for a period of hours. In the treatment of injuries it has an established place, both because of its sustained activity in the presence of blood

and other organic matter and because, unlike the irritant and corrosive phenols and cresols, it leaves the natural mechanisms of healing unimpaired. In conditions calling for repeated antiseptic application it has the advantage that 'Dettol' is nontoxic and, unlike iodine, can be repeatedly applied to the skin. In midwifery practice the 'dettolising' of patient, nurse and practitioner alike has become the most generally practised antiseptic routine.

The special claims of 'Dettol' rest not on one quality alone, but on a combination of qualities to which attention has been repeatedly drawn in papers in the medical and scientific press; above all, on a high bactericidal power against a diversity of organisms (including Strep. pyogenes, Staph. aureus, Bact. coli, and Bact. typhosum), non-toxicity, and harmlessness to tissues. Because 'Dettol' embodies in high degree these minimal requirements of a general-purposes antiseptic, it has virtually superseded every other antiseptic in the hospitals of Great Britain; and, because it is so safe and dependable, practitioners never hesitate to recommend it to their patients as the ideal antiseptic for their personal use in the home.

Brit. med. J., 1933, 2, 723.

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The manual is divided into four parts: pre-natal care, care of the baby, the premature baby, and the first two years. While a great deal of the book is necessarily 'old stuff' to the public health nurse, yet as one reads there is revealed a modern viewpoint.

The father-to-be is advised to see that his health is good, and he should have a blood-test, smear, and urinalysis. There are well-graduated exercises for the mother beginning two weeks after delivery, if allowed by the family physician. The baby's time-table is not too rigid and the advice on retaining the breast milk and on manual expression is clear and concise. The author explains how to figure out the milk-mixture when the baby is both breast-fed and bottlefed, how to wean the baby, and gives also the symptoms of communicable disease with the incubation periods.

A good deal of the fourth part may seem to be a repetition of what has gone before but the questions are those being continually asked of the public health nurse at the clinic and in the home.

The illustrations are of the best, especially those on the home-made abdominal support, and on the manual expression of breast milk. This book would be a valuable addition to the public health library as well as a guide to mothers who want to know not only what to do for the baby but why.

A Manual of Physical Therapy, by Richard Kovacs, M.D. 309 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2, 1944. Price \$3.75.

Reviewed by J. K. Mullenger, Physiotherapist, Victoria General Hospital, Halifax.

An up-to-date treatise on the subject of physiotherapy, in which each branch of the subject is carefully and fully explained so as to leave no confusion in the mind of the reader. Students of physiotherapy will find this manual a valuable aid as a reference and guide. Nurses would get a greater insight into the work of the physiotherapy department which would enable them to work in closer cooperation with therapists.

NEWS NOTES

BRITISH COLUMBIA

FORT GEORGE CHAPTER:

Five hundred miles north of Vancouver and Victoria, on the outskirts of the Cariboo Country, is the city of Prince George. To us nursing here it was like a breath of fresh air to have a visit from Mrs. Edith Pringle, deputy inspector of hospitals. It is true we did see Mrs. Pringle make a careful inspection of every nook and corner of our hospital, with notebook and pencil handy, but this did not concern us much. As staff nurses we enjoyed her at luncheon and found her completely human.

At a special meeting of the Fort George Chapter, R.N.A.B.C., Mrs. Pringle was the speaker and impressed us all with her breadth of understanding and her insight into so many problems which confront hospitals and nurses today. We were particularly interested in her attitude toward the care of the aged in the community and in her appeal for persistent work on the part of the nurse in influencing mothers in our maternity wards to do their best for their babies.

A large number of associate members were present and to them Mrs. Pringle spoke of the value of their continued interest in nursing. She made us all feel wanted by the executive bodies and told us of the particular interest of our Honourable Minister, Mr. Pearson, in nursing conditions of today. Mrs. Pringle urged us to keep growing in strength as a Chapter and so be able to voice our opinions and be ready when called upon to back the Association in its efforts to maintain the standards of the Registered Nurse, and thereby continue to give the best possible service in this Province.

MANITOBA

At a regular meeting of the Brandon Graduate Nurses Association held recently at the Mental Hospital, the speakers were Drs. Schultz and Evans, who gave a symposium on their work in neurosurgery, accompanied by illustrated slides.

The usual business meeting was held with reports from the various groups. Miss Wilkes reported that \$560 had been realized from a tag day held during Cancer Week, which was sent to headquarters in Winnipeg.

NEW BRUNSWICK

MONCTON:

At the recent annual meeting of the Moncton Chapter, N.B.A.R.N., very interesting reports were received from the various committees, showing an active year. Sufficient articles for eleven layettes have been made and donated to the Red Cross for over-



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For further information apply to:

Miss Caroline Barrett, R.N., Supervisor of the Women's Pavilion, Royal Victoria Hospital, Montreal, P. O.

Miss F. Munroe, R. N., Superintendent of Nurses, Royal Victoria Hospital, Montreal, P. Q.

TORONTO HOSPITAL FOR TUBERCULOSIS

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THREE MONTHS POST-GRADUATE COURSE IN THE NURSING CARE, PRE-VENTION AND CONTROL OF TUBERCULOSIS

is offered to Registered Nurses. This includes organized theoretical instruction and supervised clinical experience in all departments.

Salary — \$80 per month with full maintenance. Good living conditions. Positions available at conclusion of course.

For further particulars apply to:

Superintendent of Nurses, Toronto Hospital, Weston, Ontario.

seas mothers and babies. A number of articles for service personnel have also been made for the Red Cross. The Association sent during the year 6400 cigarettes to members of the armed forces overseas. Nurses have assisted every week at the desk of the Y.M.C.A.

The Association voted \$50 to the Moncton War Services Committee to help in their work of providing comforts for passengers on hospital trains passing through Moncton. In the Seventh Victory Loan drive the Association purchased a \$100 Bond.

The registry for private duty nurses has now been operating since June, 1944, with Myrtle Kay as director. Miss Kay has been appointed to represent the Chapter on a Nurses Placement Bureau that has recently been organized by the N.B.A.R.N. with head-quarters in Saint John.

ST. STEPHEN:

The annual dinner of the St. Stephen Chapter, N.B.A.R.N., was held recently in the Chipman Memorial Hospital with a large attendance. Miss Margaret Pringle, the guest speaker, spoke on "Nurse Placement Service". It was voted to purchase a \$50 Victory Bond.

The officers for the coming year are as follows president, M. Dunbar; first vice-president, C. Boyd; second vice-president, N. Spinney; secretary, T. Briggs; treasurer, Mrs. Ralph Rogers; nominating committee, N. Spinney, C. Dowling.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Irene Weirs, Department of Public Health, City Hall, Fort William.

DISTRICTS 2 AND 3

STRATFORD:

The re-organization meeting of the Stratford General Hospital Alumnae Association was held recently, and the following offi-cers were elected: president, Mrs. B. Ische; wice-president, Miss Thistle; secretary, Mrs. May Dodds; treasurer, M. McMaster; committee conveners: social, V. Fryfogle; flower, Miss Stewart, program, M. Murr.

It was decided to have a Christmas party,

in the form of a dance, to be held in the

middle of December.

DISTRICT 5

A well-attended regular meeting of District 5, R.N.A.O., was held recently in Toronto. The members divided into a General Nursing and a Public Health group for supper meetings and joined later for the evening session. Miss Pearl Morrison, the president, was in the chair and gave an illustrated talk on the highlights of the C.N.A. biennial meeting at Winnipeg. The second half of the program was in charge of the Private Duty group and the speaker was Captain A. C. Traynor, R.C.A.M.C., who told of his experiences with the troops in Italy. Student nurses from St. Michael's Hospital School of Nursing danced in Highland costume and a social hour followed.

DISTRICT 6

At the annual meeting, held in Peterborough, with Mrs. E. Brackenridge presing, reports were given of the activities which have been carried on with a reasonable degree of success for the recruitment of student nurses. The private duty nurses have loyally come to the support of the hospitals which are experiencing staff shortages, each nurse giving at least two months of this type of service. Revised private duty rates were put into effect in Peterborough. Continued activity was reported by the public health section.

Miss Gladys Sharpe was guest speaker at the evening session following a most enjoyable banquet. She described her experiences as a nursing sister in South Africa. She recalled interesting points about the trip which included a stop-over at Trinidad. She told of the opening of a new hospital in Johannesburg, with forty-eight wards, each with thirty-six beds.

The slate of officers for the ensuing year was as follows: chairman, Mrs. E. Brackenridge; first vice-chairman, Mary Ross; second vice-chairman, Janet Graham; third vice-chairman, Aileen Flett, secretary-treasurer, Anna Lynch; conveners: hospital and school of nursing, Rev. Sr. Benedicta; public health, Helen Furlong; general nursing, May Stone; membership, Maribelle Mackenzie; finance, Lois Stewart; nominations, H. Talbot, Miss Porter, H. Strath; representative to The Canadian Nurse, Mrs. H. Cole.

DISTRICT 7

KINGSTON:

Ontario Hospital:

For some time the graduates and training school staff have felt the need of an Alumnae Association and with this end in view as many of the former graduates as could be located met in the commonroom at Leahurst to elect officers and draw up the constitution. The officers elected were: president, Mrs. Wm. Newman; vice-president, Mrs. M. Lumb; secretary, Mrs. N. Ferguson; treasurer, Mrs. J. B. Garvin; committees: social, Mmes. H. E. Mills, M. E. Whire, B. Greenwood, Miss E. Seagrove; visiting, Mmes. O. Morris, J. B. McQuay, W. Quinn; councillors, Mmes R. Roach, P.





PROFESSIONAL PROBLEMS OF NURSES

By Lena Dixon Dietz. This covers opportunities in hospital and private duty nursing, industry, public health, social service, government nursing, anesthesia, X-ray, etc. as well as personal economics, legal problems, ethics and etiquette, travelling and hotel life, etc. Widely used as a textbook by schools of nursing. Third edition, 238 pages. \$2.50.

TUBERCULOSIS NURSING

By Grace M. Longhurst. A book specially for the nurse and student interested in the institutional care of the tuberculosis patient. It covers clinical tuberculosis, aseptic technic, chest surgery, behaviour problems, discharge and reliabilitation, out-patient service, extrapulmonary tuberculosis. 300 pages, 67 illustrations. New edition. \$4.40

THE RYERSON PRESS

GYNECOLOGY AND GYNECOLOGIC NURSING

By Norman F. Miller, M. D., Professor of Obstetrics and Gynecology, University of Michigan; and Virginia Bryant, R.N., formerly Supervisor of the Gynecology Wards, University of Michigan Hospital. 378

Pages, Illustrated. \$3.25.

This new book is designed to help student nurses understand the significance of diseases of the female reproductive system. It emphasizes the nurse's part in the prevention and early recognition of these conditions and develops an attitude toward this branch of nursing that is wholesome, scientific and social.

All the conditions specified by the Curriculum Guide for the course are covered, and all gynecologic nursing procedures are presented in a manner designed to make the reason as well as each step in the

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Bruce, L. Orr, J. Plunkett, N. Silver, C. Benson; representative to *The Canadian Nurse*, L. James.

DISTRICT 8

CORNWALL:

At a recent meeting of the Hotel Dieu Hospital Alumnae Association three new committees were formed to deal with new projects to be undertaken during the com-

ing year.

First, a group to study occupational therapy, with the purpose of introducing it into the hospital on a practical basis, has been formed. This group, comprised of twelve members of the Association, will study the methods used by Louis J. Haas, F.A.A.O. T.R., as explained in his book "Practical Occupational Therapy". A second group has volunteered to form the nucleus of a volunteer nursing group to aid in the hospital during the present crisis regarding nursing service. A third committee will collect and re-distribute reading material to be used in the hospital and also to send to the boys overseas. Isobel MacDonell is the convener and all contributions will be gratefully accepted.

DISTRICT 9

The twentieth annual meeting of District 9, R.N.A.O., was held recently in Sudbury with the chairman, Miss Katherine McKenzie, presiding. Members from Timmins, Kirkland Lake, New Liskeard, North Bay, Gravenhurst, and Bracebridge, including chapter representatives, attended. Thompson, acting mayor of the city, extended greetings to the guests. Miss Walker welcomed the visiting nurses on behalf of the Sudbury Chapter. Reports of Chapters and sections showed growth and development and the financial affairs of the district as satisfactory. There was an increase of twenty-seven members in the District.

Dr. H. M. Torrington, president of the Ontario Medical Association, was the guest speaker at a very enjoyable luncheon and at the afternoon session Mrs. H. Cullen ad-dressed the nurses on "Women in the Post-

War Period".

A presentation was made to the retiring chairman, Miss McKenzie, and the new chairman, Miss Sigrid Laine, was welcomed.

The graduating class of St. Joseph's Hospital were guests of the Sudbury Chapter at the dinner meeting. Miss Margaret Dulmage gave a very interesting and informative account of the work of the Red Cross in Ontario.

The following officers were elected for the coming year: chairman, A. Sigrid Laine, Kirkland District Hospital; first vice-chairman, A. Walker, Copper Cliff Hospital; second vice-chairman, R. Densmore, Sault Ste. Marie; secretary, Dorothy Lemery, Kirkland Lake; treasurer, Jean Smith, Muskoka Hospital, Gravenhurst.

SASKATCHEWAN

MAPLE CREEK:

A very pleasant luncheon was held recently by members of the Maple Creek Chapter, District 5, S.R.N.A., on the occasion of the travelling instructor's visit to Maple Creek. Miss Guillod, superintendent of the hospital, presided as hostess, and in a very gracious speech expressed the thanks of the Local Chapter for the discussion groups which had been held. Those present were Mmes Armstrong, A. Fleming, Dixon, L. Fleming, Quick, Dawson, Brooke, Misses Stockdale, and Giles. This meeting was very enlightening as to the ability of the nurses of Maple Creek and of the wonderful spirit of helpfulness which the married nurses are displaying.

SASKATOON:

At the November meeting of the Saskatoon Chapter, S.R.N.A., much enjoyment was caused by a cleverly enacted pantomime presented by student nurses from St. Paul's Hospital. The "heroine" of the play was a young student nurse home on vacation. Many hilarious scenes were presented and the fact that no lines were spoken added much to the merriment. The program also featured vocal solos by a student nurse from the City Hospital. Lunch was served by members of the program committee.

A recent meeting of the Saskatoon City Hospital Alumnae Association took the form of a "Dutch Auction". Many delicious articles of food were "knocked down" to lucky bidders. Student nurses, ably assisted by the president, Miss M. R. Chisholm, were the capable auctioneers. Members enjoyed this departure from the usual routine meeting and the coffers of the Association were

swelled by the proceeds.

YORKTON:

The graduate nurses of Yorkton recently called a special meeting to consider the organization of a Yorkton Chapter, S.R. N.A. Mrs. Kate Chapman (Hunt) presided and the registrar of the S.R.N.A. spoke on the proposed re-organization. Reference was made to the valuable work done by Yorkton Volunteer War Service Association since the outbreak of war. However, the consensus of opinion was that members of this association give their support to the formation of a Chapter as a more permanent type of organization.

The splendid assistance given by married nurses in this District, as well as many others in the province, was also apparent. As our travelling instructor says. "We owe much to married nurses, and in expressing appreciation must not forget the husbands and grandmothers who come to the rescue and help out by accepting responsibility for some of the household duties. For even mothers are human and cannot be in two

places at once".



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Tupper was born at Amherst, N.S., July 2nd, 1821. He studied medicine at Edinburgh University where he received the degrees of M.D. and L.R.C.S. in 1843. Of medium height, erect, and vigorous, Charles Tupper had an abundance of nervous energy which contributed to alertness and ceaseless mental activity. His manner was hearty and genial and he had a broad grasp of most topics.

In 1862 Tupper was appointed a Governor of Dalhousie College, Halifax, where he initiated a medical course which reached full fruition in 1870. It was largely due to his persistence that in 1867 the Victoria General Hospital began its existence in Halifax as a provincial and city institution. When the Canadian Medical Association was formed in 1867 he was elected President.

The year 1855 marked the beginning of Tupper's political career. It is said that history will record the four years of his administration as Premier of the Province of Nova Scotia as the greatest era in Tupper's life—an era in which he achieved the most striking personal success. Against strong opposition he established a system of free schools for Nova Scotia.

Tupper was the apostle of Confederation and played an important part in the passage of the British North America Act. He actively supported efforts to establish a Federal Department of Health which, after much missionary work, became a reality in 1919.

He was made a Baronet in 1888. For two different periods he held the position of High Commissioner for the Dominion in London and in 1896, was made Prime Minister of Canada.

Sir Charles died at "The Mount", Bexley Heath, England, on October 30th, 1915. The record of his life is a challenge to the medical profession and inspires William R. Warner & Company in their policy of Therapeutic Exactness...Pharmaceutical Excellence.

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Reader's Guide

In recent months, nurses have been called upon to assume more and more responsibility for treatments and practices which customarily were done by the doctors. The extent to which they might be held responsible should any untoward accident occur has been a source of worry to many. Trenholm L. Fisher, M.D., F.A.C.P., who discusses these problems for us is secretary of the Canadian Medical Protective Association. His paper was originally presented at a meeting of the nurses of District 8, R. N.A.O., at Ottawa.

With so much publicity being given to the use of blood plasma and transfusions, it is well for us to be informed regarding the abnormal conditions which may occur even in apparently healthy individuals. Joshua J. Chesnie, M.D., is an interne on the staff of The Montreal General Hospital.

Lillian E. Martin, R.N., M.T., is a graduate of the Class of 1927 of the Calgary General Hospital and is at present in charge of the laboratory at the Calgary Associate Clinic. Her description of the procedure in connection with Dicumarol therapy is based on the work which she is doing in conducting the daily prothrombin tests.

Mrs. Edith Pringle is Deputy Inspector of Hospitals in the provincial service in British Columbia. Her paper was given as a part of the program at a refresher course for hospital superintendents and administrators held in Vancouver. Mrs. Pringle has had extensive personal experience as a hospital executive and asks us some challenging questions.

Mrs. Selena Henderson is closely associated with the program which she has outlined. She is on the staff of the Mental Hygiene Section, Division of Child Hygiene, in the city of Montreal.

Continuing her series of articles re-

lating to supervision in public health nursing, Mildred I. Walker, chief of the Division of study for graduate nurses, Institute of Public Health, University of Western Ontario, London, Ont., discusses what is included in adult behaviour.

Elizabeth Braund has been director of the Provincial Placement Service in British Columbia since the inception of the development there. Her outline of the form of Service offered, the means of financing, and the general plan of organization may serve as a guide for other provinces contemplating the organization of a similar type of Service.

Though many of our hospitals have taken steps to provide for some form of extracurricular physical activity for their nurses, few have adequate facilities of gymnasium, swimming pool and necessary equipment to make such a program possible and retain the active interest of the participants. A description of what can be accomplished even under difficulties has been outlined by Kathleen Clifford, surgical supervisor at the Central Division, Montreal General Hospital. Miss Clifford is a sports enthusiast herself and was winner of the Westmount Women's Singles Tennis Championship in 1944.

Being a patient at the Hospital for Sick Children, Toronto, isn't half bad when there is a chance of a sleigh-ride through the snow. The two youngsters pictured on our cover were convalescing at the Thistletown Branch of the Hospital for Sick Children.

Several interesting letters have been loaned to us and excerpts from them appear in next issue. We feel that every one is anxious to hear more about what our nursing sisters are doing on the various war fronts. We would be glad to receive more of these letters to share with our readers. Special care will be taken to return them to the lenders. Have you some to send?



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(1) West. J. Surg., Obst. & Gyn., 51:150, 1943. (2) Am. J. Obst. & Gyn., 46:259, 1943. (3) Clin. Med. & Surg., 46:327, 1939. (4) Med Rec., 155:316, 1942.

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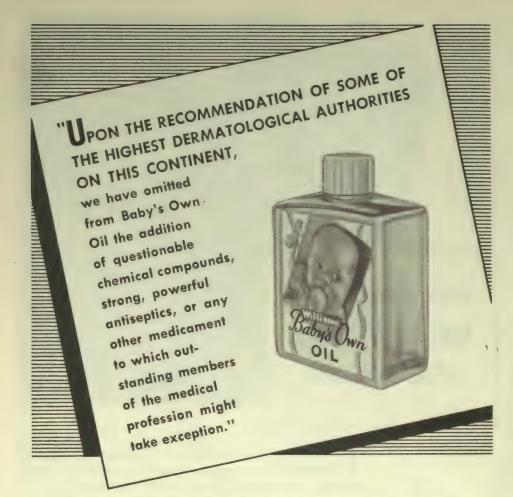


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CANADIAN NURSE

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Necessary Ingredients

For a long time now, appeals have been made through the newspapers, over the radio, in the nursing literature, and by various other means, for more and more nurses to help to meet the demands for nursing care. Hundreds and thousands of married or retired nurses have answered these calls and are today filling positions in our hospitals, with public health organizations or carrying on in private duty. Many of these nurses have home responsibilities, in addition, and are therefore working a good deal longer than the regular eight-hour day. Many are beginning to feel that the work is an effort but since the job has to be done, they remain on duty. Usually only one part of an individual is used up in doing any particular piece of work. Other parts get dammed up and a pause is necessary to enable the nurse to become a whole person again. This pause we call the leisure period, and a brief consideration of how it can be made most profitable may help us to meet the

commotion and rush of the busy days that lie ahead with great equanimity.

"Doing" and "not doing" are both aspects of being. When at work, the nurse is needed. Relaxation comes when necessity is withdrawn from her activities. The moment that work stops, she becomes less important, temporarily, and enters a period of indifference to external pressure. There is an element of choice open to her and a chance of making values, as it were, from within.

Many people cannot just slip from work — they have to throw it off. The hours on duty have involved a certain tightening up. While loosening up again, one must do nothing or appear to be doing nothing. Washing, tidying, a change of dress, a bath, even lounging, are very useful ways of loosening up, of relaxing. It is important to remember that if we are with other people, we can relax best when they do not set up tensions or remind us of tensions set up earlier. Laughter is a prime relaxing agent.

Both body and mind should relax the body in as pleasant and comfortable surroundings as possible, the mind in light reading, chatting with contemporaries, etc.

If relaxation leads on to recreation, the nurse will emerge re-created. Perhaps, because the off-duty hours are usually filled with endless trivialities which obscure our perspective, it is difficult to work out a purpose or plan which might justifiably be called adequate. George Herbert, who wrote at the turn of the sixteenth century, said "He hath no leisure who useth it not". Since leisure should be of a kind which automatically reduces all personal problems to a minimum, the solution probably lies in developing hobbies, preferably two; one for indoors and one for out, even though they may point in opposite directions.

A hobby is one's favorite subject or occupation that is not one's main business. It is healthy if it can be laughed at and/or shared. There are endless varieties of things which can be taken up

as hobbies. Perhaps the commonest is some form of collecting. People often associate the starting of a collection of articles with the pre-adolescent years but no nurse is too old to begin. The chief difference will lie in the type of objects collected. Books, recorded music, pictures, stamps, china - she can go on listing until she finds the thing she is most interested in and her hobby starts there. For the nurse who is skilled with her hands, there is an infinite range of things she can make. Out-of-door hobbies include not only the various sports but again the collecting urge may be satisfied.

Over two thousand years ago, Dionysius the Elder, being asked whether he was at leisure, replied, "God forbid that it should ever befall me". We have learned a great deal since then. We know there is something wrong with the person who has no outside interests, who does not use her leisure. Let us relax and recreate so that we may do our work more efficiently.

-M. E. K.

February

Though February is so brief, she is intriguing, quite, when trees are innocent of leaf, and days are short but bright. Beneath our feet how crisp the snow, o'erhead, how blue the sky, with all the blustering winds that blow as clouds go scudding by. One day the gentler note of Spring comes float-

ing on the air, reminding us of birds that sing, the flowers that bloom so fair. And on the wings of that glad thought our hearts are light and merry as on our calendar we jot adieu to February.

-MARY M. FORMAN

Preview

Inaugurating what we hope will grow into a regular feature of the Journal, the March issue will feature a composite picture of the present-day knowledge of Rheumatic Fever. Dr. James H. Graham will introduce the topic with a discussion of the causes of the disease, the symp-

toms, and both the therapeutic and suggested prophylactic treatment. Mildred M. Brogan outlines the nursing care in the acute stage. Evelyn Pibus rounds out the study with an analysis of the public health aspects and some sound advice to nurses going into the homes.

Legal Responsibilities and Privileges

TRENHOLM L. FISHER, M.D., F.A.C.P.

There can be no doubt that if you had found the proper member of the legal profession he could have given you a more precise definition of the legal responsibilities and privileges of the nursing profession than I can. Such knowledge as I have has been gathered rather by indirection than by deliberate intent in the course of some duties which make it necessary for me to decide, always with Counsel at my back, where physicians' responsibilities begin and end. There have been occasions when these have impinged on nursing responsibilities and anything I can say to you has become known to me in that manner.

Here I would like to thank Mr. E. F. Newcombe, K.C., General Counsel of the Canadian Medical Protective Association, for the help he gave me. He read over the first draft, culled many of the inaccuracies, and added much valuable information that otherwise you would not have had.

Not many of us give the law more than a passing glance when we are afraid we have transgressed in some particular and for that reason most of us, when we do meet it, have a slight rise in blood pressure and a fervent hope that we may never have any closer acquaintance. A few of us shun it because we agree that "the law is a ass". All of us who hold those opinions forget the other side of the question. We forget that the law represents a great part of the accumulated wisdom that men have acquired about how to live with each other, how to define their several positions and, even more important, how to protect themselves from predatory action of any kind by their fellows. The law, as well as forcing us to accept some responsibilities, protects us against unfair demands.

Then, too, nearly all of us fail to

realize that while the law can be and is very specific about many things it is a body of opinion arrived at by and laid down for ordinary persons who are engaged in many diverse activities. Obviously it would be impossible to be specific about every particular activity and, therefore, the law tends to lay down general principles which may be regarded as more or less fixed, at least pro tem, and to apply these principles to the solution of particular problems. When once a solution has been arrived at, it often is used in subsequent similar cases. In other words, it becomes a precedent and while it is not "law" it has the force of law because, again pro tem, it is the best solution available for the particular problem.

This fact is of the greatest importance with respect to medical and nursing legal problems. It is literally true that there are no specific "laws" stating what a nurse may or may not do, or - if rarely she be lazy — how little she can do. Nursing responsibilities are poorly defined in law. Actually, reference to such legal literature as I have been able to obtain suggests there are no "laws" governing the responsibilities and the conduct of nurses, although their own Registration Act does define, to some extent, their privileges. Although if precedents hold there are few to follow because comparatively few nurses have been brought to court to have their conduct judged - I leave it to you to decide whether the profession as a whole has earned this untroubled state! Further, as with any profession, the profession of nursing has changing responsibilities which force changes in the application of the law. The many new duties, some accepted eagerly and some reluctantly, which have devolved upon nurses as a result of the present shortage, are a case in point. Many of them will be relinquished gladly when the emergency is over, but a few will remain and new precedents will be found to govern the manner in which such duties must be fulfilled. So, with respect to the nursing profession not only are laws few and general in application, but due to changing circumstances the applications of the general principles are constantly changing. What is unusual for a nurse to accept as her duty today may be commonplace and accepted tomorrow.

Now let us see if we can decide from a nursing point of view what are the duties of nurses, and then perhaps we can apply some legal principles to these activities. First and foremost, of course, really the only reason for a nursing profession is the nursing care of patients. This care is made up of several things. The actual physical care of the patient, the provision of cleanliness and comfort and optimum conditions for cure are basic things and have been basic since there was a nursing profession. With the greater education and increased knowledge of that profession over the years, more and more actual medical treatment, under the guidance of doctors, has been delegated to nurses—the doing of dressings, the administration of medicines and physical therapy. Hospitals, too, have delegated authority and responsibilities to nurses in increasing degree. They are expected to keep records of patients' temperatures and pulse rates, they keep records of the patients' condition - much more detailed records of the small important things than, unfortunately, many doctors keep and thirdly there are occasions when nurses, as a result of the knowledge and training they have received, do things which to them seem necessary without orders. In other words they exercise their own professional judgment.

Thus, you see, a nurse — every nurse — is something of a Pooh-Bah. She may be, in a legal sense, the servant of the doctor; she may be the servant of the

hospital, or again she may be responsible only to herself for the exercise of her professional judgment.

Perhaps we can dig a little deeper, define a little more precisely. What are the duties of the nurse when she is the servant of the doctor? It would seem reasonable, and it is true, that her duties are to carry out his orders. Granted she does that and does it properly, her responsibility is discharged. Any error or unfortunate result following is the responsibility of the doctor. If, however, the nurse does not carry out the order properly and an unexpected result follows, the responsibility is hers. For example, a patient has a pain which the doctor thinks may be relieved by the application of heat in the form of a hot water bottle, which he requests the nurse to apply. The application of the hot water bottle is not the whole story. True, unless she carries out the order she is remiss and may be penalized, but as well, she has been taught the proper temperature at which to have the water in the bottle, and even if she follows out the order she is remiss if she uses water so hot it burns the patient. By custom - precedent if you like - it has come to be accepted that the doctor need not say "apply a hot water bottle at such and such a temperature". He expects the nurse, as a result of her training, to know the proper temperature. She, not the doctor, will be penalized if an error is made and the patient burned.

There is an exception to the general rule that a nurse escapes responsibility if she follows a doctor's orders. If an order is recognized by a nurse, or ought to be recognized by her as unusual or incorrect, and if she carries it out without confirming it, she may have to share responsibility with the doctor for any untoward results.

A similar state of affairs exists when legally the nurse is the servant of the hospital. Some duties are expressly laid upon her by the hospital and if she fulfils these competently, her responsibility is ended. Any error or unfortunate result following therefrom is the responsibility of the hospital. But if the nurse fulfils the orders carelessly and harm results, hers is the fault.

Third and last is the most difficult to discuss — the occasions when nurses exercise their own professional judgment. So many things must be considered that we had better enumerate a few of them. It goes without saying that the individual holding herself out as a nurse must have had nursing training. It would seem equally evident, but unfortunately is ignored all too often, that she must have kept abreast of the advances in medical science. No nurse, for example, can nurse intelligently a severe diabetic who does not know something of the action of the various kinds of insulin, when their actions are exerted, what the times are of reactions to different kinds of insulin. Similarly no nurse fulfils her duty to a surgical case who has not learned the complications to be watched for and the new nursing procedures that will speed recovery. Then, the nurse must apply her knowledge in a careful fashion, "with due care and skill". If she fails to exercise due care and skill, she is guilty of negligence. Negligence is such a relative matter, so inclusive and so varied in its meaning, that the law has a general description which may be applied to particular cases. Mr. Justice Wills, about 1865 or 1870, said, "Negligence is the absence of care according to the circumstances", and any comment on that definition is sheer redundancy. As Mr. Newcombe said, "It reminds us that there is no absolute or intrinsic negligence; it is always relative to some circumstance of time, place or person."

When trouble arises for the nurse in any given case this knowledge lets us surmise the grounds on which she will be judged. Irrespective of the cause of the nurse's failure, whether the usual signs were masked by something else, or there was an atypical response, or the nurse had insufficient knowledge, the points at issue would be how much the nurse should have been expected to know, how much she did know, and whether she used due care and skill in applying her knowledge. They are nice points. How can anyone decide whether another knows enough and applies her knowledge sensibly? Reasoning by analogy from comparable situations where doctors have been involved, I will venture an opinion that I think is reasonable. In the case of doctors the law says their knowledge and skill must be that of the average of other doctors in the same district doing the same type of work — "the average standard of competent men in the circumstances in which he or she is placed". So it is probable a court would apply this principle to a given case and endeavour to learn whether or not the nurse had average knowledge and applied it as skilfully as the average competent nurse would have done. The answer to that question would help a court decide whether the nurse was guilty or was not guilty of negligence or malpractice.

Many of us, in our fear of the law, fail to remember that while it is stern it is also reasonable and was designed to govern the conduct not solely of the brilliant — or the stupid — but of average individuals. It by no means demands perfection under all circumstances. Ill results may attend a person's best efforts and this in medical practice as in other things. The law recognizes this and as long as it can be shown that the individual's best efforts were put forth, no penalty will be imposed. It has been said this way, "where an operation to be performed is complicated and difficult, a doer may err and be unsuccessful, and yet not be responsible if he or she fairly exert the best of his or her judgment". This is extremely important and remains important although modified by the fact that the "doer" must have adequate knowledge and must have kept that knowledge up to date.

Other factors arise constantly which

modify a nurse's responsibility. Consideration has to be given to the nurse's training, whether it was adequate or inadequate, in relation to the duty she accepted. That is, had the nurse any right to accept responsibility under the circumstances, or should she, in terms of her training, have refused? Then, too, should she have been asked to perform the duty? That brings us to another question. No doctor or institution should ask a nurse to perform an act for which, reasonably, she could not be expected to have sufficient knowledge or training unless the doctor or institution is willing to accept responsibility for the work done. These things the nurse must weigh in her own mind after which she must accept or refuse the request.

An interesting point with respect to nurses relates to breach of professional confidence. Where doctors are concerned, professional confidence must be maintained and the law provides protection for the doctor so doing. In the case of nurses professional confidence is a matter of ethics rather than law. Certainly the nurse should respect the confidence of her patients but the legal compulsion differs from that exerted on doctors. If the nurse does not and as a result of her talk harm to the patient is alleged, she may be held responsible for her utterances just as any other individual is. The patient may sue and if he proves his point it is probable judgment would be given against the nurse. Because nurses' opportunities for learning more things which should be held in confidence are greater than those of other individuals, their danger from loose talk is greater and it behooves them to be circumspect about professional matters.

Many of the applications of the law to present-day things, to the things nurses are doing, for example, during the present emergency which properly are not nursing duties, or at least have never been regarded as such in the past, I have left till the last for discussion. I am aware of your interest in them and

it is only my own inability to deal with them specifically that makes me want to avoid them. Should nurses give intramuscular injections? do intravenous work? give anesthetics? One general answer may be given. If the training received by the nurse included the procedure and if she can demonstrate her fitness to do the work as a result of her training, then by all means do it. If on the other hand her training did not include the procedure and such knowledge as she possesses has been gleaned haphazardly, then by all means refuse to do it. But you say, this is an emergency, internes are few, doctors are busier and the need is great. Well, just remember that unless a doctor or a hospital will stand behind you in the event of trouble the load will be yours alone. You have no other protection. The burden of proof will be upon you to show that you possessed the necessary skill.

Let me digress a moment to impress on you the significance of that statement "the burden of proof will be upon you to show that you possessed the necessary skill". Under ordinary circumstances, that is, if a nurse is charged with failing in something for which she was properly trained, it is incumbent on the plaintiff to demonstrate beyond reasonable doubt wherein the nurse failed. Sometimes this is difficult to do and the defence is relatively easier. If, however, the nurse did something for which she was not trained, then a plaintiff would need merely to state this and immediately to win her case the nurse would have to demonstrate beyond reasonable doubt that her training or experience was sufficient. This is much more difficult. Stop for a moment and think how much more difficult it would be to win a case by proving that a nurse knew how to give a hypodermic than it would be to win by forcing someone else to prove she did not know how to give it.

Another digression by way of explanation. One of my duties is to advise doctors how best to avoid some legal troubles. There are at least two ways to advise them. The doctors may be told just how close they can come to breaking the law without actually doing it, or they may be advised what course of action will follow the spirit as well as the letter of the law, and so be well within its provisions and therefore safe. This latter is the only prudent course, the only safe course. It is the reason for this advice to you.

In general nurses do not receive training for any of these procedures. It might be very difficult or impossible for a nurse to prove that she, as an individual, had had adequate training and had acquired the ability to perform them. Failing such proof, whether or not an ill result were due to something beyond the nurse's control, her position would be difficult and it is likely she would be penalized. Therefore do not do these things. It may be difficult to refuse but you have the example of one of the great nursing organizations in Canada to encourage you. It is my understanding that the Victorian Order of Nurses does not allow its nurses to do intramuscular and intravenous procedures, and in general for the reasons I have given.

There is one other piece of advice that is of value now and probably will become of increasing value. While nurses seldom are sued alone, they are being implicated in increasing numbers in suits directed primarily against doctors or hospitals. It is all too common to learn that nurses are without any financial help in the conduct of their defence. Malpractice insurance is available and can be taken out. The actual cost is comparatively little and is well worth while. It is seldom that one can defend oneself against a charge of malpractice or negligence at a cost less than several thousand dollars. That figure may be revised downward if the case does not get to court, and many do not, but it would certainly have to be revised upwards if the trial were a long one. Considering the number of nurses and doctors, suits against them are rare, but for the individual in trouble, without financial backing, that fact is of little comfort — while an insurance policy giving protection against the costs of a malpractice action is of great comfort.

Coagulation and Thrombosis

Joshua J. Chesnie, M.D.,

Coagulation and thrombosis are two different processes although the basic elements in their formation are the same. Coagulation of blood is a process which takes place after blood has been removed from the body. It also occurs within the body after death. Thrombosis, however, is an active process which may develop in the living body while the blood is circulating, and cannot occur following death. The theory of clotting or coagulation which

follows is known as *Howell's Theory*, although further work has been done which has upset many of Howell's concepts.

When an injury is received and blood is shed, a solid clot composed of a network of fibrin threads is formed. The protein fibrinogen of the plasma is converted to insoluble fibrin by a ferment called *Thrombin* which in turn is formed by the interaction of calcium salts with prothrombin. You may ask, why

doesn't all this occur constantly since the blood contains ionized calcium? This interaction is prevented by an antiprothrombin in the blood called *Heparin*. The anti-prothrombin and prothrombin are in such balance that if some thrombin is formed in the blood, it is immediately neutralized by the anti-prothrombin. However, when an injury occurs, a substance is liberated from the injured tissues or from the platelets of the blood itself, which is called *Thromboplastin*. This substance neutralizes the anti-prothrombin thus allowing clotting to take place at the site of injury.

Why is coagulation so important and why are we so interested in coagulation and prothrombin time? What does this all mean? Obviously, intravascular clotting in a living person is not desirable but clotting at the site of injury is not only desirable but very important. If clotting time is increased, that is, if it takes longer than normal for blood to clot, then the individual may lose a great deal of blood and such loss may even prove fatal. As we have seen, prothrombin is necessary before the clotting process takes place. We can determine by checking the prothrombin time whether or not the individual has a normal quantity of prothrombin, or is manufacturing the desired amount.

It has been found by different workers that prothrombin is manufactured in the liver. It has also been discovered that vitamin K is necessary for the manufacture of prothrombin. In obstructive jaundice the prothrombin concentration of the blood is depressed because of failure to absorb vitamin K from the intestine; vitamin K is a fat soluble vitamin and, due to the absence of bile secretion, the fat is not absorbed. You can see how important it is to know the coagulation and prothrombin time in a patient with obstructive jaundice due to a stone in the common bile duct, for example, upon whom surgery is contemplated. With these people, the use of vitamin K is a lift-saving measure.

Before I go on to discuss the use of vitamin K, there are several conditions associated with decreased coagulability of the blood which should be noted, the most outstanding of which is hemophilia. In this disease, the females are not affected but they transmit the disease to the males who are called "bleeders". The essential defect in this disease is a deficiency of a coagulant which Howell believes to be thromboplastin. Another disease is purpura hemorrhagica which is associated with a great reduction in platelets and, as a result, a decrease in thromboplastin. Frequently, splenectomy is followed by an increase in platelets and quite often a cure.

Vitamin K is known as the antihemorrhagic or coagulation vitamin. Its importance pre-operatively has been mentioned. It is well represented in the foods we eat as, for example, cereals, carrots, yeast and wheat germ. It is a substance that can now be made synthetically. Its use in pediatrics and obstetrics is so important that its routine use as a prophylactic has not only reduced the incidence of cerebral hemorrhage in the newborn but has altered the clinical picture to some extent, symptoms of late bleeding being practically eliminated.

Low prothrombin in the newborn results from failure of the fetus to receive sufficient vitamin K, in utero. The administration of the vitamin to the mother, even an hour or two before delivery, increases the child's prothrombin enough to protect it from hemorrhage. As a result hemorrhagic disease of the newborn should now be regarded as preventable. Even if it has been neglected before delivery, infants' prothrombin time can usually be raised sufficiently to arrest bleeding within two hours by means of vitamin K.

Now, a few words about thrombosis. Where a clot is composed mainly of fibrin, a thrombus has as its chief constituent the platelets, although fibrin is associated with the thrombus. For a thrombus to form, the blood must be

moving. The situation in which thrombosis is of most importance to you in the nursing profession is when a thrombus forms in a patient convalescing from an operation or from a debilitating illness. There is nothing more heart-breaking to both doctor and nurse than to see a patient, who is apparently on the road to recovery, abruptly keel over with a cry of pain, have a sudden onset of pallor and sweating, and in a few moments breathe his last.

There are many reasons for thrombosis. I will mention a few, but the one I am going to emphasize is post-operative thrombosis, where the circulation becomes sluggish due to weakened heart action. This may occur in any vein in the body but the most important and frequent site is in the femoral vein, especially following an operation on the abdominal or pelvic organs. Several factors are involved in this formation. The retardation of the blood stream permits the platelets, which are the lightest cells in the blood, to settle out at the periphery of the stream and adhere to the wall of the blood vessel. Thromboplastin is liberated and, ultimately, fibrin threads are formed which entangle the white and red cells. After an operation, also, platelets are increased in number and show a greater tendency to clump together. The platelets accumulate on the walls of the veins and form ribs or beams which attract more and more platelets forming a spongy mass in the stream. The leukocytes, due to their lower specific gravity, separate from the red blood cells and adhere around this mass thus eventually blocking off the vessel.

To prevent post-operative thrombosis certain measures must be taken: the respirations of the patient are stimulated. Early and frequent movement of the limbs is encouraged. Anti-coagulants, such as heparin or dicumeral, are indicated for patients who have had pulmonary embolism and pulmonary infarction. Thrombosis may occur in the blood vessels due to inflammation and

trauma but I have emphasized postoperative thrombosis because careful and intelligent nursing procedure contributes to its prevention.

In these days of war and speeded-up industrial activity the use of blood and plasma as life-saving measures is much to the fore and every citizen is very aware of their use. Many substitutes have been used to make up the loss of blood due to hemorrhage but the ideal replacement is blood itself. In certain conditions, such as burns, plasma is extremely valuable. On the battlefield actual, blood is not available so that plasma has to be used as an emergency measure. That is why the development of dried plasma is such a great step forward in war medicine and surgery.

As you may know, not everyone can give blood to everyone else. Every person is in a definite blood group. There are four major groups and, using the international classificiation which is the one most universally used at the present time, they are: O, A, B, and AB.

The three workers who were most responsible for classifying blood like that were Landsteiner, Jansky and Moss at the beginning of this century. It was quite a while before methods for transfusing blood were developed. Anastomosing a vein of the recipient (patient) with an artery of the donor was tried first; then the plan of using a surgical team was developed, one drawing the blood by syringe and the other giving it to the recipient. Nothing was added as an anti-coagulant since the blood was given before it had time to coagulate. At the present time with the development of blood banks and methods of indirect transfusion, a glucose citrate solution is being used as an anti-coagulant.

Why has the blood been placed in four separate groups? Blood plasma or serum contain substances which are capable of agglutinating red blood cells. These substances, called agglutinins, are thought to be attached to the globulin

fraction of the serum. The red cells may or may not contain substances which are capable of uniting with the agglutinis called agglutinogens; so the red cells may have A agglutinogens or B agglutinogens or both AB agglutinogens or neither A nor B agglutinogens, thus giving us O agglutinogens.

It has been found that if the blood has A agglutinogens and α anti-agglutinogens — the anti-A agglutinogens—the blood will agglutinate in the blood vessels. The agglutinin or anti-agglutinogens in type A blood is β agglutinin or anti-B agglutinogen. AB blood has O agglutinin and type O blood has both α β agglutinins. Why this should be is not known. To put it down briefly the groups go like this:

Agglutinogens	Οα β	agglutinins
Agglutinogens	Αβ	agglutinins
Agglutinogens	Вα	agglutinins
Agglutinogens	ABo	agglutinins

You see why group A cannot receive group B blood and vice versa—because the α or anti-A agglutinins would cause agglutination of the red cells in the recipient.

Group AB is known as the universal recipient since, when transfused by any other group, the cells of the recipient do not agglutinate. Group O is known as the universal donor since its serum usually does not affect the cells of the recipient.

In recent years, further study has revealed that there is more to the story of transfusion than this simple explanation would indicate. In a great many cases when groups of the same type were crossed they were found to be incompatible. The reason is that sub-groups and other factors in the red cells have been discovered, such as, the Rh factor, A₁ and A₂ sub-groups, the M and N agglutinogens, the P factor and the H factor. They all may be in the blood at the same time or they may be absent without relationship to other agglutinogens which may be present.

This additional knowledge is important where repeated transfusions are given to a recipient because he may develop agglutinins to an anti-agglutinogen of the donor's blood — M and N in the human is not one of these but the Rh factor is. The Rh factor or agglutinogen is of particular significance. Awareness of it explains a lot that has occurred in transfusion reactions, particularly in obstetrics and pediatrics, in compatible groups where the donor was the husband.

The Rh factor was discovered when workers Landsteiner and Wiener injected red cells of the Macacus Rhesus monkey into rabbits and guinea pigs producing an anti-monkey (anti-Rh) serum which was able to agglutinate the red cells in the rhesus monkey. It was found that the serum of 85 per cent of humans was able to do the same thing. These people, or rather, their blood, came to be known as Rh (after the rhesus monkey) positive. Those 15 per cent whose blood could not do this were known as Rh negative.

Levine found that the transfusion reactions occurred in women in childbirth, after having been transfused with the husband's blood due to the fact that the women were Rh negative whereas the husbands were Rh positive. The reason for this reaction is that the Rh factor is a hereditary dominant. If the fetus is Rh positive the Rh factor, which can be transmitted per placenta, caused the anti-Rh factor to be developed in the mother's circulation. If a transfusion is required by the mother, and it happens that the blood she receives is Rh positive, then agglutination with the donor's cells will take place resulting often in a fatal reaction.

There is a disease of the new-born known as acute hemolytic anemia or erythroblastosis fetalis which usually ends fatally. It has been found that these babies are Rh positive, the mother Rh negative, and the father Rh positive. In this case, the mother has developed anti-Rh agglutinins, as mentioned above,

and these have passed back through the placental circulation and have reacted with the red cells of the infant to produce this fatal condition.

In passing, I will mention cold hemagglutinins. These are present in people who, when exposed to cold weather, may develop hemoglobinuria, acute hemolytic anemia, or blueness of the extremities due to agglutination and resulting hemolysis of his own red cells. It has been found to develop after an attack of primary atypical pneumonia and may last for years.

Transfusion, as you can see, is a very serious and very important procedure. In transfusing a patient, the blood must be carefully typed and carefully crossmatched. False negatives and false tests may be obtained because of the cold agglutinins and other factors in the mind and checked because a transfusion blood. All these things must be kept in reaction is always serious and sometimes fatal. Once the blood is in, it is in, and cannot be removed. The recipient should be carefully watched and if he has any complaints of chills, pain in back or flanks, pain down the legs, a feeling of pressure in the chest, or even a feeling of anxiety that he didn't have before the transfusion was started it should be stopped. These symptoms are a sign of intravascular agglutination. Reactions can be treated but with not so much success if they are severe. Fluid should be forced by mouth and parenterally but the best treatment is prevention.

In conclusion, may I say that I have given just a bare outline of a subject that is of extreme interest and importance. I hope that it will stimulate you to read further on what has been left unsaid here.

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Daily Prothrombin Tests in Dicumarol Therapy

LILLIAN E. MARTIN

The increasing use of an anticoagulant to reduce the prothrombin level of the blood and so reduce the chance of clotting has been of much value in preventing such accidents as thrombosis, pulmonary embolism and certain venous thrombotic states.

The most common hemorrhagic agent in use is heparin which, owing to the difficulty of purifying and the necessity for continuous or repeated intravenous administration, has proven very costly. A substitute for heparin, which could be used for clinical appli-

cation as an anticoagulant; has been developed, based on independent studies by Schofield of Canada and Roderick of the United States which revealed that the eating of spoiled sweet clover caused hemorrhagic disease in cattle. In 1941 Professor Paul Link and his associates of the University of Wisconsin isolated and crystallized the active principle that was responsible for this condition, namely "Dicoumarin". Since then a series of brilliant investigations by Meyer of the University of Wisconsin and Butt and Allen of the Mayo Clinic have resulted

in the discovery of a synthetic compound that is identical in biologic characteristics, namely "Dicumarol".

During experiments the following tests were done on individuals, both before and after the administration of therapeutic doses of Dicumarol: red blood count, white blood count, urinalysis, blood sugar, N.P.N., creatinine, liver function, icterus index, serum calcium, bilirubin, renal function, blood platelet count. No pathological changes were found in these tests, but there was some question of increase in the sedimentation rate.

Dicumarol is administered by mouth in gelatine capsules since soluble salts for intravenous use have not been found to be stable. The administration of Dicumarol has not been attended by any symptoms of toxicity other than hemorrhage, which probably resulted from an overdose. Following administration of Dicumarol, regardless of the size of dose, there is always a latent peroid of twenty-four hours, sometimes forty-eight hours or even as long as seventy-two hours, before the reaction on prothrombin time is apparent. Depending on the duration of therapy, and to some extent on the total dose, the time required for a return to normal may be two to ten days and is usually five to six days.

During Dicumarol therapy, frequent urinalyses should be done to detect hematuria. If the operation is on the gastro-intestinal tract the stool should be checked for blood. No two patients react alike; some bleed when the prothrombin time is increased five times, while others can go as high as ten times.

Daily Prothrombin Time Estimations Must be Done

Vitamin K in ordinary doses has not as yet been shown to be an antidote in combating increased prothrombin time resulting from Dicumarol therapy. Transfusions of fresh whole blood, fresh citrated blood or fresh plasma should be given and, as the result may

be only temporary, repeated transfusions may be indicated. It has been proven that the prothrombin concentration of stored blood or plasma falls rapidly with age. After the latent period there is a gradual increase in prothrombin time until the maximum is reached, usually three to five days. Administration should always be controlled by daily prothrombin time tests. The Magath modification of Quick's method is advised.

DICUMAROL THERAPY

This test is very delicately balanced and correct technique is of the greatest importance. The exact mode of action of Dicumarol is not known. One theory is that some action within the body is necessary for it to be effective, as it has been proven that Dicumarol added to blood in vitro does not affect the prothrombin concentration. It is assumed that Dicumarol acts on the liver and retards prothrombin production. After the prothrombin present in the blood at the time of administration of Dicumarol is used up, there is a noticeable prolongation of prothrombin time — this explains the latent period of twenty-four hours or more.

Dosage:

At the Mayo Clinic dosage is based on the following suggestions: If the normal prothrombin time is eighteen to twenty-two seconds, Dicumarol is administered to produce and maintain a prothrombin time of twenty-five to sixty seconds. The physician in charge must individualize the dosage on the basis of the clinical condition of the patient and on the laboratory findings. Prothrombin time estimation is always checked before the administration of Dicumarol. They suggest that the total daily dose be given at one time after the prothrombin time for that day has been determined, remembering that all patients do not react alike. Like the Mayo Clinic, Wright and Prandoni of the New York Post-Graduate School of Medicine, suggest using a small initial dose, with larger doses to follow being determined by prothrombin time estimations. Contrary to this, Meyer, Bingham and their associates of Wisconsin recommend a larger initial dose followed by daily smaller doses.

Practical, safe and effective dosage appears to be based on giving 5 mgm. per kilogram of body weight for the initial dose, and controlling subsequent doses by daily prothrombin time estimations.

It must always be borne in mind that there is a latent period of at least twenty-four hours after administration. If immediate effect on blood coagulation is desired, heparin may be given and Dicumarol started at the same time. Heparin will not affect prothrombin time but will affect blood coagulation at once. It may be given for twenty-four to seventy-two hours.

Administration:

Dicumarol may be given to patients on sulphathiazole or sulphadiazine therapy without ill effects. Dicumarol may be used as a prophylactic on patients having a succession of surgical procedures or if there is a history of intravascular clotting. It is necessary, however, between operations, to allow the prothrombin time to come back to normal. Dicumarol should never be given to patients with prolonged prothrombin time (unless, of course, previous administration has caused it). It should never be given to patients bleeding from any cause or purpura of any type. It should never be used if there is an ulcerating or granulomatous lesion. It seems to cause definite hazards if administered to those patients with sub-acute bacterial endocarditis. It is not advocated for use where patients have continuous tube drainage of the stomach or small intestine.

Dicumarol should be used with caution in the following cases:

1. Debilitated patients.

- 2. In the presence of liver or renal dysfunction, especially where there is jaundice, hepatic cirrhosis or enlargement of the liver.
- 3. During menstruation, menorrhagia or metrorrhagia.
- 4. To patients having surgery on the brain or spinal cord chiefly because of the extreme danger of the results of hemorrhage.
- 5. Dicumarol has a tendency to have an increased effect on febrile patients or those taking salicylates or aspirin.

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Preview

While his paper on the early development of pediatrics as a specialty will be of greatest interest to nurses in the province of Quebec, we felt that all of our readers would enjoy the account of it written by Dr. Harold B. Cushing, emeritus professor of pediatrics at McGill University.

Advisory Board on Nursing Education

The Council of the Royal College of Nursing has set up an advisory board on nursing education under the chairmanship of Sir Cyril Norwood, M.A., president, St. John's College, Oxford, with Miss E. E. P. Mac-Manus, O.B.E., S.R.N., matron of Guy's Hospital, and chairman of the Education and Training sub-committee of the Nursing Reconstruction (Horder) Committee, as vice-chairman.

The object of the advisory board is to ensure that nursing education benefits by the advances in educational methods and facilities which are characteristic of present developments, and to enable all those participating in the post-certificate education of the nurse to obtain help and advice which is both educationally sound and professionally appropriate.

The personnel of the advisory board includes educationists representing the universities, general education and the medical and nursing professions.

Many factors have, in the last twenty years, brought into prominence the educational side of the training of the nurse. The introduction of State examinations for nurses in 1925, the development of post-certificate qualifications for sister tutors, health visitors, midwives, nurse administrators, ward sisters, industrial nurses and other nurse specialists in the inter-war period, and the recommendation of the Athlone Committee that pre-nursing courses be established in the schools, have all led to increased educational activity with the necessary integration of the profession and other educational authorities.

For instance, the schools, since July 1939, have begun to prepare nurses for their professional examinations in anatomy, physiology and hygiene, and the nursing and medical professions continue the education of candidates during their period of training. Universities, colleges and polytechnics have helped to promote post-certificate nursing education.

Before the war twelve to fifteen thousand girls entered the nursing profession for training on an average annually, and the number has now increased. Between nine and ten thousand of these enter for the preliminary and final state examinations and from six to seven thousand qualify as State registered nurses each year. In addition an increasing number of nurses take post-certificate courses to qualify for the many fields of work now open to State registered nurses; the College itself has over one hundred post-certificate students at the moment at headquarters alone. The total extent of the educational work involved is great; in comparison four thousand women supplemented by two thousand men teachers were trained on an average each year before the war.

It is obvious that there must be close links between the nursing profession and educationists generally, especially since the Education Act will raise the school-leaving age and increase the facilities for vocational training for such professions as nursing in the schools, and because refresher and post-certificate qualifications will be in increasing demand as the national health service becomes established and the recommendations of the Rushcliffe Committee become effective.

The Council hopes that this Advisory Board will help to further these links, and will enable the College of Nursing to carry out more fully the articles of its Royal Charter, which give it the power "to promote the science and art of nursing and the better education and training of nurses", and the right to "institute and conduct examinations in all branches of women's work conducive to the efficient conduct of the nursing profession, and to grant certificates and diplomas to those who pass prescribed examinations" and "to provide, establish and maintain offices, examination halls and lecture rooms for courses of lectures and demonstrations" for the nursing profession.

Preview

What do you know about the International Council of Nurses? How did it get started? What are the plans for reviving its activities in the post-war world? Because there are so many of the

newer graduates who are unfamiliar with the International organization we asked Grace M. Fairley, who is third vicepresident, to prepare a brief outline of its history and development.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses
Association

Adult Behaviour in Relation to Supervision in Public Health Nursing

MILDRED I. WALKER

In the evaluation of the public health nurse much stress has been placed on certain personality traits such as tact, poise, initiative, ability to get along with people. It was very pleasant to recommend a nurse with such traits. However, these were not related to the total situation so did not mean much. It is realized now that personality traits must not be isolated but must be considered in relation to the total situation. Certain standards of adult behaviour have been evolved and an adequate program of supervision in the field of public health nursing might well be built around these recognized criteria. They should be applied alike to the administrator, the supervisor, and the nurses who participate in giving guidance to the families and the individuals in their community.

Emotional adulthood does not just happen, it must be developed. With the stresses and strains of life we may not remain at the adult level so those who guide others must be aware of the characteristics to be expected so that they may point the way to emotional adulthood. The more often we react in an adult manner, the more definitely the pattern is established and the easier it will be to respond satisfactorily. Intellect, per se, is not a guarantee for a happy life any more than physical build or great

possessions. It is the co-ordination and integration of the physical, mental, emotional and social traits of the individual which produces or releases a wholesome personality.

When intellect and soma (body) are both normal, two factors for satisfactory living are present. A third essential is fullness of emotional development or adulthood. Intellectually, the adequate adult arrives at her own opinions and follows her own conclusions in handling life's difficulties. She does not seek counsel indiscriminately and is not at the mercy of suggestions which come from the people about her. Therefore, she is not dependent upon constant advice or admonition. She selects all the factors in the given situation, she weighs them or evaluates all their relationships and decides what is best to be done, then she acts, and accepts the responsibility for her action.

CHARACTERISTICS OF EMOTIONAL ADULTHOOD:

1. Ability to adjust at the social level: She is able to get along with people. She has the ability to adapt satisfactorily to new situations but her adaptability must be evaluated on the level of her edu-

cation and experience or her social (professional) level.

The negative aspect is shown by one who (1) cannot carry responsibility; (2) has not learned to renounce; (3) withdraws from society because of shyness, lack of social interest, sense of inferiority; (4) has to be handled with gloves on; (5) cannot co-operate but always dictates (creates authoritarian social climate in an executive position); (6) feels the world owes her a living; (7) takes unfair advantage of others; (8) goes about with a chip on her shoulder; (9) cannot bear to postpone pleasure—unable to delay responses; (10) draws on sympathy of others, selfpity (poor-me attitude); (11) requires coddling; (12) is a parasite (unable to sustain herself physically or wait upon herself).

2. Emancipation from the parental roof including parents or any compulsive form of authority. This does not entail being belligerent or over-submissive towards parental ties but should enable the individual to graduate from infantile meekness and acceptance to the ability to make her own adjustments. "Peace at all cost" is not always adjustment on an adult level. Just as the kite rises against the wind so is a certain amount of opposition a good thing. It can be accepted as a challenge to better performance. Concentration of responsibility in one person is not a concentration of authority. It is the establishment of leadership. The true leader will encourage self-dependence and thinking in her guidance.

3. Full heterosexuality: One must learn to work with the opposite sex with equal objectivity and friendliness. This is one of the most important aspects of adulthood. The negative reaction is an infantile or adolescent tendency to cling to an immature type of behaviour: (1) to take childish pride in being a spinster; (2) to take a thin-lipped and prudish attitude towards the natural functions. People often manifest unlovely psychological representations in some de-

partments of their own lives; (3) to show intolerance, smug complacency, obsession for orderliness, over-meticulousness about dress, miserliness, and in general an insurmountable parsimony in giving of themselves generously to society.

4. A satisfying philosophy of life: We must work out for ourselves some system of ideas that will reconcile us to having been born. We must be purposeful, and set up a satisfactory philosophy of life. The reverse side of the picture shows such negative responses as: (1)

For many —
Life is a place
Where we dig in the ditch
To get money enough
To buy food enough
To get strength enough
To dig in the ditch

(2) Infantile philosophy which says, "In so much as I was not consulted about being born, I take no responsibility and I mean to get as much out of life and give as little in return as possible". One's reward in life is according to the contribution one makes. In the family, we are accepted as a personality, as a part of a whole, but we are accepted in society for the contribution we make towards our work group and play group.

(3) Problems presented are so vast, that it is futile to make an effort. This happens in public health nursing where the policies are not well defined or where too much is expected of one nurse in a community or a district program where her case load is too heavy. Point out here that there is never a final "end result". The goal when reached becomes a means to an end. Life is an ongoing activity and our philosophy must be attuned to growth.

WHAT TO DO ABOUT IT:

Evaluate the whole situation. If we hitch our wagon to a star let us make the goal attainable, that is, within our capacities. Our philosophy of life is not a garment but a part of the fabric of our exis-

tences. It will assist us to adjust and adapt to new situations. Our philosophy must have no finalities. Our emotional health represents our achievement of "at homeness" and of peace with the people in our universe. It means that we recognize ourselves as an integral part of society and that in considering the welfare of society we thereby advance our own. It means we recognize the unity of rights and obligations; that there can be no rights without comparable obligations. With responsibility comes freedom but also with freedom comes responsibility.

Therefore, in the evaluation of the individual in public health nursing, relate her total personality and her performance to the total situation thus

avoiding the outmoded emphasis on isolated personality traits, unrelated to the situation under consideration. If the individual shows characteristics which are not on the adult level, seek out the reasons and guide her to raise her levels of effectiveness to the adult behaviour pattern. There may be some abnormal conditions of which the supervisor is not aware, but which if known, could be ameliorated. Also there are persistent problems for which there is no solution and this must be accepted. Thus, the individual may be assisted to improve her performance through the development of a wholesome personality which is a subtle but forceful influence in creating the democratic social climate essential for healthful living.

The Value of Mental Hygiene in the School

SELENA HENDERSON

Mental health should be thought of as a part of general health. The nervous system is one part of the person. While it is one part of a whole it is so closely integrated that it cannot be separated except for purposes of discussion. The nervous system plays the prominent role in forming those connections between the individual and his environment which will enable him successfully to adjust himself to his environment. So we may say then, that the unadjusted person is one whose habits and skills are inadequate to meet the demands of the situation or who lacks the ability to solve the problems which are met in the course of everyday living. On every side we see them. They are the timid and retiring, the bullies and tyrants, the delinquents and criminals.

The mental hygienist points out that behaviour is the result of a cause, that misconduct is a symptom, and seeks to understand the underlying motive for

conduct and to effect a rearrangement of the irritating situation with the result that the misconduct vanishes. Up to the present mental hygiene has devoted its attention to the remedial treatment of the problem child and it is of this phase of the work we will speak. Nevertheless the day is approaching when mental hygiene will be the guide in all the human relations of the school; when the teacher in the classroom will have learned to interpret behaviour in terms of the drives which it satisfies and the thwartings for which it compensates rather than in terms of laziness, stubborness, obstinacy or stupidity.

Mental hygiene has been established in the schools of the larger cities of Canada for some years. In the United States it has progressed far in advance of Canada and medical-social set-ups which include psychiatric service are found in all the larger schools widespread across the country.

What is the procedure in our work in the schools of Montreal? As stated before, at present we deal for the most part with the problem child. Who is the problem child? From the point of view of the school he is the child who repeats a grade, is a chronic repeater or presents a behaviour problem.

Our procedure in the attempt to solve these problems is:

1. The administration of tests: (a) physical, to look for physical weaknesses or defects; (b) intelligence, to determine the general intelligence level of

the pupil.

2. The interview with the pupil himself covering his reactions toward school, the conditions of his daily life, his ambitions and plans, his tastes and interests, activities, companions, attitude toward members of his family and so on.

3. The visit to the home in order to understand the home influences surrounding each child and to attempt to influence the parents to make whatever adjustments are necessary.

The test used for the most part in ascertaining the I.Q. (Intelligence Quotient) is the Binet-Simon, Stanford Revision. This test has stood for years as the outstanding example of carefully and scientifically standardized tests. It is individual, taking about one hour. It is made up of an extended series of tests in the nature of problems, success in which demands the exercise of intelligence. The scales consist of fifty-four tests so graded in difficulty that the easiest lies well within the range of normal three-year-old children while the hardest tax the intelligence of the average adult. The problems are designed primarily to test native intelligence not school knowledge nor home training. It does not attempt to measure the entire mentality of the pupil nor to bring to light special talent.

For children who are mute, do not understand English or who may have more ability to deal with things than words the Pintner-Patterson test is used. This is a "performance test" using a form board with openings of various shapes cut out of it and blocks which must be fitted into those openings. A number of types of form boards are used.

What actually do we mean by an I.Q.? The intelligence quotient refers to the relation between the child's mental development and what we should expect of him at his chronological age. One is born with a certain mental capacity which does not alter appreciably throughout life.

The results of the Binet-Simon test are graded as follows:

Above 140, near genius or genius; 120 to 140, very superior intelligence; 110 to 120, superior intelligence; 90 to 110, normal or average intelligence; 80 to 90, dullness; 70 to 80, borderline deficiency; below 70, definite feeblemindedness; 60 or 70, mental debility superior type; 50 to 60, mental debility inferior type; 25 to 50, imbeciles; 25, idiots.

About 2 per cent of the children in a school have an I. Q. below seventy. The mental development of these children will stop somewhere between the seventh and twelfth year level, more often between the ninth and twelfth year level. They may drag along to the fourth, fifth, sixth grades but even by the age of sixteen to eighteen years they are never able to cope successfully with the more abstract and difficult part of the school course of study. These children constitute a large percentage of our problem children in the school. Therefore mental capacity having been ascertained by means of an intelligence test, placement in a special class solves many problems.

There are special classes in many of our Montreal schools. Here each child receives individual instruction progressing in proportion to his mental ability. Emphasis is placed on developing motor functions and placing children as much as possible in everyday life situations.

Along with it the fundamentals of simple academic subjects are taught and instruction given in acceptable moral and social attitudes and behaviour.

In one school in Montreal we have what we believe is unique in Canada, an opportunity class or rather two opportunity classes, one taking in grades three and four the other the older group grades five, six, and seven. The children in these classes have very superior intelligence. They also are given individual instruction. The idea is not to speed up but rather to broaden the curriculum by permitting the child to branch out into other subjects, do projects, and so forth, according to his aptitude and interests. Here again placement in the opportunity class often is the answer to a problem.

Problem-cases in the school range from simple ones which are quickly solved to most complicated and involved ones which require prolonged effort on the part of all concerned to bring about a satisfactory conclusion.

Sydney was a boy of thirteen and a half years, problem truancy. An intelligence test showed a mental age of eight years eleven months, an I.Q. of 66, mental debility superior type. A visit to the home disclosed he was the eldest of three boys, a shy under-sized lad with defective vision but who would not wear his glasses, and smaller than his brother who was a year younger. The home was a miserable one in a poor district although there was evidence of attempts on the part of the mother to keep it clean and home-like. The father had been in the army for two years, stationed away from home. The mother worked part-time in a restaurant to augment the family income. She was a loud-voiced, rather brazen woman but sincere in her desire to do her best for her family. She co-operated with us willingly and well. The brother was also tested and although he was found to be somewhat slowminded, nevertheless he could do the work in an ordinary classroom. Sydney depended on his younger brother entirely and wanted to be put in the same room with him, but, he needed to go in the special class! Both boys were placed there though for John it was only temporarily until Sydney became adjusted to his new surroundings. This arrangement has worked satisfactorily and Sydney is now attending school regularly.

Patricia was six and a half years of age in the first grade. Although she attended school regularly she could not do any of the work of her grade. Her mother came to the school to inquire about her poor report expressing her belief that Pat could do the work but didn't, and that the fault lay with the teacher who not strict enough with the child. Pat's tests showed her to have a mental age of five years giving her an I.Q. of 78, borderline. At the teacher's request the mother obtained a morning off from the war plant where she worked in order to come to the school for an interview with the mental hygiene nurse. During the discussion it was learned that Patricia was very slow about carrying out directions and was nagged continually, not only by her mother (the father is overseas). but also by grandparents and uncle, with whom the family lived, for her "stupidity". Patricia, it was also discovered, was under the doctor's care for "nervousness". An explanation of Pat's mental ability was given to the mother and the harm this constant nagging was doing pointed out. Proper methods of handling the child were discussed. At the end of the conference the mother asked to speak to the teacher with whom she was able to talk over Pat's progress from a different and more amiable point of view, and finally agreed the wise course was to place Pat back in kindergarten.

A different problem was presented by Albert aged six years eleven months and in grade one. His teacher reported his school progress poor in spite of great effort on his part. A test revealed a mental age of seven years two months giving an I.Q. of 103.5, normal intelligence. A brief survey of this small, pale undernourished child showed that the main factor in his lack of progress was malnutrition. The case was turned over to the school nurse for intensive work with the mother in proper nutrition and child training.

Barbara aged eleven and a half years was in grade four. Her teacher reported that "the girl is always trying to copy from someone, not so much to cheat as that she realizes her own inability". Her test gave Barbara a mental ability of ten years seven months an I.Q. of 92, normal. She was a shy child, one of a family of eight children whose father was a labourer. She lacked

self-confidence to a marked degree and responded visibly to urging and encouragement. It was obvious that the reason she copied other children's work was that she had no faith in her own!

Corinne aged nine years ten months was also in grade four. This teacher reported "Corinne doesn't seem to be poor in any particular subject except arithmetic, but she does not co-operate in any subject nor lesson so fares badly at testing time. Her attitude is sullen. When going up to the blackboard she deliberately saunters. She laughs loudly and makes rude noises and when reprimanded becomes sullen and irritable. Her school attendance is irregular, no reason being given except that 'she doesn't feel like coming' ". Corinne's test showed a mental ability of nine years five months giving an I.Q. of 96, normal. She was a shy, deliberate child. Rapport established she co-operated willingly and well. But if she was hurried, the question just asked would leave her mind entirely. She presented a good example of "a feeling of inferiority and the unconscious attempt to compensate for it". This bidding for attention and noisiness was her method of compensating for her feeling of insufficiency. The teacher's attitude changed entirely after the cause was explained to her, and Corinne's response was good.

Blanche aged fourteen years was in grade seven and was doing very poor work. A test revealed a mental ability of ten years eleven months giving an I.Q. of 78, borderline. Her parents were planning on withdrawing her from school and sending her to business college. A visit disclosed a home in a poor neighbourhood, inadequately furnished but clean and home-like. The father was in the army, the mother working as a ward maid in a hospital. Blanche was the eldest of three girls. When the nurse arrived she was busily and happily preparing the supper, having completed the marketing. Blanche is a welldeveloped, rather attractive girl with a pleasant personality. When the mother arrived Blanche's future was discussed with the result that in view of her age she will repeat grade seven then go into service of some kind such as housework, cook, waitress or seamstress rather than waste time and money on a business course in which she would never make the grade.

It will be noted in the study of these cases that not all the remedial work is done by the mental hygienist. More often her task is to seek out the underlying causes of the misbehaviour, to make those concerned see the situation as it is and to enlist their aid in effecting an adjustment to a more favorable situation. The principles of mental hygiene should penetrate to every corner of the school, should permeate the whole educational system. The day is approaching when this will happen; when every teacher, as a part of her training, will be given a full understanding of the principles of mental hygiene. What a revolution this will bring about in our whole educational system! Even now the mental hygiene point of view with its emphasis on the attempts to effect adjustments is rapidly displacing the old ideas of discipline. Whereas formerly the formation of right habits of conduct and thinking were taken care of in the home and church, the complexity of our modern civilization has rendered this course no longer feasible. More and more these things are being left to those responsible for the child's education. And since the whole child comes to school and the school is responsible for the child as a whole why is not this in very truth the better way, providing the teachers are well-adjusted and adequately trained themselves? No longer can the school hope to remain a place where only academic subjects are taught but more and more it is becoming responsible for the formation of those right habits of behaviour and thinking which will produce well-adjusted individuals, able to fill happy and useful places in society. This is a protection not only for the individual but for society itself. Mental hygiene, theoretically a science, in reality in its everyday applications is an art, which like the little acorn develop into the mighty oak - a tremendous weapon to influence the future generations of our nation.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A.

Organization of the Hospital Nursing Staff

EDITH PRINGLE

Let us not dwell on the difficulties of the past few years in relation to nurse shortage and the many problems that ensued as a result but rather look forward and plan carefully for the future. The problem of stabilization of nursing service and the rehabilitation of nurses is one that will require the best we all have to give. Just as there have been gains and losses on the battlefields in Europe, we have also made certain gains and also suffered losses in the civilian fields of nursing administration. The gains made now depend on leadership and direction. While it is difficult to organize a nursing staff without nurses, nevertheless we are not going to attract nurses or keep the ones we have unless there is sound organization within each and every hospital. The organization of a hospital depends very largely upon the administrator. To organize the nursing staff we require nurse administrators capable to giving leadership and direction. We are all interested in doing a better job. We are all agreed that to command or boss is not our aim but rather that we give leadership.

Within a hospital we are working as a group and without co-operation and co-ordination all is lost. How we can make this group activity a happy and, at the same time, a satisfying experience for those with whom we work is a question that we should all study. First,

there must be centralization of authority. It takes special effort on the part of someone in the organization to tie the whole together and make each person feel related to the whole. Second, this central authority must be the co-ordinating force which provides administrative practices. The administrative or executive job requires a person gifted as a leader. The job itself includes: Planning and defining policies and procedures. Organizing the activities of others. Delegating authority and responsibility. General orders and instructing. It is a co-ordination of all the various efforts and includes the important task of stimulating and vitalizing all the individuals who are contributing their part. It consists of combining the human energies in a way that creates a new and satisfying harmony of effort, where indifference becomes conviction and inertia initiative. Passive consent gives way to active participation and new levels of attainment are reached.

More effective results are obtained by leadership than mere direction. It has been said, "To be properly led is a moral right. To lead properly is a moral responsibility". Organizations now command executive direction plus leadership. A leader requires energy, enthusiasm, friendliness, integrity, decisiveness and intelligence. The good leader is a good teacher. Good training can

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largely take the place of order-giving but sound planning is required.

The job of a leader, a manager, an executive or a supervisor, is to get people to do more readily what they ought to do and to get them to enjoy doing it. Our value as a leader is based upon our capacity to accomplish just that; in other words, it is not the direction of things but the development of the people with whom we work. This calls for a perfect understanding between the various groups of workers and between the workers and their leaders. If we are to give the best care to patients and obtain the best results from our workers we must start from the foundation and build a solid structure. We must not however overlook the welfare of the worker. Without proper working conditions we cannot hope to attract the type of women we desire in the nursing profession nor, alternatively, can we keep nurses in the nursing profession.

A nurse may do an excellent piece of work in one hospital and fail hopelessly in another. This failure may be due to lack of direction or to misunderstanding. Personnel work must of necessity be personal work if it is to be effective. There must be an intimate personal relationship between the management and the individual worker. Personal work cannot be just a mechanical procedure. It requires study, analysis and planning; not only analysis of the job and of the workers as individuals but a lot of self-analysis on the part of the administrator or supervisor.

Are we giving what we should? Are we leaders? Do we try to do the job ourselves or do we delegate authority? Have we planned the job so that we know where we are going? Do we know how to organize the activities of others? Do we lead or do we drive? Have we a staff education program? Do we consider staff education as "in-service" training? Have we set out the policies and procedures in ward manuals for the guidance of our staff? Do we keep

close to the workers? Do we avoid job irritants? Do we present the job to the worker in a fair and comprehensive manner? In other words do we really orient our workers? Have our nurses the proper equipment to carry out their service to patients? Do they receive adequate pav? Do they work longer hours than necessary and if so, do we know why? Do we really know how very necessary it is that employees are contented and feel that there are opportunities for development and advancement? Satisfactory working conditions oftentimes mean more to an employee than the salary.

Are we fair? Are we helpful? Are we inspiring? Do we confer with our workers? If so, are our conferences what they should be? Do we outline new policies at our conferences? Are they educational? Do all participate? Do we know how to give constructive criticism? Do we know how to deal with grievances?

Let us consider some of these points. What of staff education? To make a program for staff education function we must have a plan. The good sound plan requires study and hard work. To function successfully it requires working together. This includes the nurse administrator, the supervisors and staff nurses. Staff education should stimulate each and every nurse. Planning has been defined "as the best use of time and energy. It is the way in which the administrator knows what she is doing and what is taking place in the institution". It is a basic administrative principle in organizing and in supervision. To construct a plan we must analyze the situation. Study the findings - determine the needs - formulate a plan and put it into action. No plan remains static; it requires study for adjustment or re-building. In planning we must also evaluate. What are the results of the plan in terms of nursing service, the staff, and self? Is the staff co-operative and are they interested? What of

self — what have I learned — face up to failures, why do they occur, am I the reason or what?

Training does not stop with the acquiring of special skills. It must be extended to the development of the nurse as an individual, functioning unit of the organization. We must, therefore, bring into our staff education program an opportunity for continued growth, opportunities for advancement and recognitions for ability. The nurses should be made to feel they belong to the hospital staff and should feel secure. They expect protection and moral support. They should receive accurate knowledge regarding the hospital policies and procedures. It has been said: "Through group thinking members gain a perspective and a common understanding of aims, policies and methods of accomplishment in a way that is not possible for any one to secure alone. It develops a staff spirit".

How important, therefore, is the staff conference! To have a successful staff conference we should make adequate preparation and have a prepared agenda. All nurses should participate. Much valuable information can be given to staff members at the staff conferences.

information regarding new policies, etc.

The chairman of the conference becomes the teacher who guides the procedure but does not dictate the end or solution. She must know all the ramifications to assist in guiding but not dictating. The nurse administrator should stand prepared to abide by the conclusions reached which represent the group, its knowledge and its purpose.

What type of staff conference do you have? What is the result? Do the nurses present their problems or do they consider the periods useless and a fag, or worse still just a time for someone to find fault with them. To my way of thinking the length of the conference is important. It can be too long.

Some questions we should ask ourselves could be as follows: Are we precise in outlining the particular point for discussion? Do we clarify meanings? Do we keep the meetings impersonal? Do we direct discussion toward a definite objective? Do we summarize the discussion in a helpful way? Do we sense when it is time to cut off discussion and formulate an integrated solution? Do we attempt to get out the deeper reasons behind superficially expressed differences?

Provincial Placement Service

ELIZABETH BRAUND

Some years ago nurses in Canada and the United States recognized a need for a professional Service or Bureau which would assist in solving the problems resulting from poor distribution of nurses, and lack of adequate counselling and guidance. In 1938, the Council of the Registered Nurses Association of British Columbia appointed a committee to study the whole situation with a view to setting up a Provincial Placement Service. War emphasized the need for such a Service and hastened the work of the committee.

At that time there were no nurse placement bureaux in operation in Canada and the ones which were functioning in the United States were planned to meet nursing conditions and requirements which were very different to those existing in British Columbia. The result was that the Committee had little which could be used as a pattern when they drew up the "Outline of the Functions of Placement Service". There is ample proof that exhaustive study was put into the outline. It was soon felt that some changes in it would make for smoother

running of Placement Service, but in the main the outline served as a good guide.

Another consideration which provoked considerable thought was that of financing the project. This too required much study. Finally a plan to increase the annual registration fee from two dollars to five dollars was adopted by the nurses at an annual meeting of the Registered Nurses Association of British Columbia. Two dollars of each fee was allocated to the financing of Placement Service. It was realized that this was an insufficient sum to meet the full cost of the undertaking and government grant funds were a welcomed supplement to the revenue. Thought is at present turned towards planning for a time when Federal Government Grant funds may not be available.

In April, 1943, the British Columbia Provincial Placement Service was established. To date only registered nurses and graduate nurses who are holding permits which allow them to practise their profession under the sponsorship of the Registered Nurses Association of British Columbia are placed by the Service. The machinery is available for the placement of subsidiary nursing groups but the Registered Nurses Association is not in a position to place them at present, although it is the intention of the Association to offer this service as soon as the way is clear.

Placement Service undertakes place nurses in all branches of nursing. Placement of nurses, with the exception of private duty nurses and a limited number of nurses who are placed in temporary general staff positions, is the function of the Provincial Placement Service. Because private duty calls are received at any time during the twentyfour hours, Regional Branches of the Provincial Placement Service were organized in Vancouver and Victoria to facilitate the filling of such calls. Similar branches will be organized in other communities when the need for them is demonstrated.

After the outline of the functions of the Placement Service had been followed for a year, it became apparent that Placement Service would function more efficiently if there was some reorganization in the "Chain of Responsibility" and if the duties of the Provincial Placement Bureau Committee, the Advisory Board and personnel were more clearly defined. Since the new "Organization of Provincial Placement Service" may prove useful to those provinces which are in the process of forming a Bureau the plan is appended in its entirety.

The "Chain of Responsibility" can more clearly be understood if we study a problem which may arise in a Regional Branch. The director of the Regional Branch first undertakes to solve the difficulty. If she cannot do this she passes it on to the director of the Provincial Placement Service. If the latter requires advice she presents the problem to Provincial Placement Bureau Committee. In the event that a solution cannot be found and the community interest is involved or it is obvious that lay and professional advice outside of nursing would be beneficial it is referred to the Advisory Board, whose decision goes back to the Provincial Placement Bureau Committee. If further advice is necessary it is taken to the Council for discussion. In any event, all recommendations of the Provincial Placement Bureau Committee must be endorsed by the Council.

The present difficulties which are encountered should tend to become less as Placement Service gains the confidence of all employers and nurses who use the service. From the beginning we have been faced with an insufficient number of nurses to fill all vacancies. Not only is there a shortage of nurses but this is accentuated by the frequency with which many nurses change their positions. Since the use of Placement Service is entirely voluntary it is found that all nurses have not enrolled. This situation is gradually improving as nurses become accustomed to making use of the Service, and are acquainted with

many advantages which Placement Service offers. These include accurate and up-to-date lists of vacancies with details regarding the terms of employment. Other benefits which nurses receive come under the counselling portion of the Placement Service program and include guidance regarding the type of work for which the applicant's preparation, experience and ability best suit her, and suggestions for further post-graduate study to prepare her for future positions. Another advantage the nurse enjoys is the introduction she receives to the employer. This may take the form of an interview which has been arranged on her behalf or a letter addressed to the prospective employer giving her qualifications and places of past employment. After the nurse has personally experienced the many aspects of the Service it is usually found that she readily turns to Placement Service when she is again in need of help.

As the service is so new it has not always been easy to convince employers of the benefits of Placement Service. Once their confidence is gained we find them returning repeatedly for assistance. This statement is made in spite of the fact that there are not available nurses every time an employer lists a vacancy. Nevertheless, there are countless ways in which employers find Placement Service usful besides filling a vacancy. These include reliable reports concerning the applicant, as well as information regarding trends in salary, working and living conditions.

It is the real hope of the Registered Nurses Association of British Columbia that Placement Service will fill the place in the community for which it was designed. If it succeeds it will be a source of reliable information when surveys are conducted to ascertain the supply and demand for nurses, their working conditions, their salaries and their job satisfaction. There will be a higher proportion of nurses in positions for which they are suited and employers will receive applications from nurses who are best qualified to fill the vacancies. In other words. the quality of nursing service will improve, there will be more equitable distribution of nurses and nurses will be better prepared for their positions as a results of available vocation counselling.

Organization of Provincial Placement Service

Objectives:

- 1. To meet the need for nursing service within the province.
- (a) To maintain a high quality of service through careful selection and placement of nurses.
- (b) To bring into closer association and to co-ordinate the efforts of all those engaged in or concerned with the employment of nurses.
- (c) To undertake studies of employment problems as they affect the community and the nursing profession.
- (d) To act as a clearing house for any hospital, organization or private individual requiring nursing service and to serve on a 24-hour basis as a private duty directory.
- 2. To provide vocational counselling to nurses.
 - (a) To assist a nurse in obtaining a posi-

- tion and in the field of nursing best suited to her preparation and potentialities.
- (b) To obtain up-to-date information concerning positions and professional opportunities for nurses.
- (c) To secure credentials of any nurse who desires to identify herself with Placement Service.
- (d) To maintain a cumulative record of each nurse enrolled.

Organization:

- 1. Membership:
 - (a) Placement Bureau Committee:
- (1) Chairman shall be named by the Council: (2) Chairman of the three Provincial Sections; (3) Chairman of the Advisory Board to the Placement Service Committee; (4) A representative of each District or Chapter sponsoring a Regional Branch; (5) Ex officio members: president

of the Registered Nurses Association; registrar of the Registered Nurses Associaion; director of Placement Service; (6) The Councillors as defined in the present act.

- (b) Core Committee of the Placement Bureau Committee:
- (1) Chairman of the Provincial Placement Bureau Committee; (2) registrar; (3) president of the Registered Nurses Association; (4) director of Placement Service; (5) to be appointed by the Provincial Placement Bureau; (6) to be appointed by the Provincial Placement Bureau Committee.
- (c) Advisory Board: (Advisory to Provincial Placement Bureau Committee)
- (1) Chairman appointed by Placement Bureau Committee; (2) a representative of each District or Chapter sponsoring a Regional Branch; (3) one Doctor; (4) one representative of the Council of Social Agencies; (5) one representative of the Hospital Association; (6) registrar of Registered Nurses Association; (7) director of Placement Bureau; (8) chairman of the Placement Bureau Committee.

2. Functions:

- (a) Placement Bureau Committee:
- (1) To appoint a Director of Provincial Placement Bureau Committee on the recommendation of the Registrar; (2) to recommend to the Council the organization of additional Regional Branches as the need for them becomes apparent; (3) to examine the budget set up by the Director and make recommendations to the Council before the 31st day of January each year; (4) to define policy; (5) to act in a consultant and advisory capacity to the Director of Placement Bureau; (6) to develop new functions as the need for them is demonstrated; (7) if and when it is deemed advisable, to establish categories into which persons engaged in rendering nursing service can be placed.
- (b) Functions of the Core Committee: The Core Committee shall have the authority to execute the functions of the Placement Bureau Committee between meetings of the Committee.
- (c) Functions of the Advisory Board: To act in an advisory capacity to the Placement Bureau Committee on all matters referred to the Board by the Committee.

Duties of the Director of Provincial Placement Service:

(a) to put into effect the policies outlined by the Provincial Placement Bureau Committee; (b) to prepare an annual budget

for presentation to the Provincial Placement Bureau Committee; (c) to supervise the organized Regional Branches; (d) to recommend and to assist in the development of additional Regional Branches as the need for them is indicated; (e) to assist in the development of such Directory Service as may be indicated in those areas which have no Regional Branches; (f) to collaborate with the Registrar in the implementation of studies; (g) to maintain an efficient record system, such as, statistical information, accumulative records for all nurses enrolled; (h) to inform the public, the medical and nursing professions of the objectives and functions of the Service as authorized by the Committee; (i) to co-operate with those organizations and individuals who have a responsibility for and an interest in providing an adequate and efficient service to meet the health needs of the community.

Duties of the Director of a Regional Branch:

(a) To put into effect policies of the placement of private duty nurses as outlined by the Provincial Placement Bureau Committee; (b) to collaborate with the Director of Placement Service in the implementation of studies affecting private duty nursing.

Termination of the Waiver Clause

The Registered Nurses Association of British Columbia gives notice that nurses who graduated from approved schools of nursing prior to April 22, 1921, and who did not obtain a certificate of registration, may make application for registration without examination up to but not after *April 20, 1947*. The termination of this privilege is provided for in Clause XV of the Registered Nurses Act, assented to March 15, 1944:

"For a period of three years after the coming into force of this Act, upon application and payment of the registration fee by such person, the Council at its discretion may admit to membership without examination any person, otherwise qualified, who graduated from a school of nursing before the twenty-second day of April, 1921".

Any nurse in the above mentioned category who wishes to make application may obtain the necessary form from Miss Alice L. Wright, Registrar, Registered Nurses Association of British Columbia, 1014 Vancouver Block, Vancouver, B. C.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

Rambling Thoughts by a Nurse Returned from Overseas

I. BRITTON

Life in England was indeed pleasant for the group of ninety nurses in the field unit to which I was attached. Bicycle rides along the beautifully quiet and scenic English country lanes occupied many off-duty hours.

Places of historical interest were particularly fascinating as, for instance, old Clarendon Palace where lived many notables, amongst them the instigators of the Reformation. Do you want to see it? Then just thread your way up a long hill by a narrow bicycle path, go through some trees and there you see the stone doorway with its inscription, added in later years. You can climb over parts of the huge fireplace and make out the figure of a dragon worked out on the bricks in lighter colored clay. On the way back let's stop along the bank of the river Avon. (England has many rivers called Avon). We will remove our shoes and ankle socks and go paddling. It's April and the water is cold but the sun will soon warm our feet again.

Tomorrow afternoon there is an invitation to tea. We are free at four o'clock; you see we work a straight 8-hour shift. The tea is with the Chamleys' who live on a farm six miles away. Peddling along we meet a tractor pulling a three-bottom plow just as we are passing a quaint thatched-roof cottage,

literally smothered with roses and honevsuckle. Our friends on the farm tell us all about what they are doing. We find that Mr. Chamley formerly taught at the Royal Agricultural College and now supervises this thousand-acre farm and has students there for practical experience. There is a huge, rambling stone house with three staircases and I don't know how many rooms. What fun we have! And for tea - soft cooked eggs - perfect! We haven't seen an egg since we were last on a farm for tea! We ride back in the moonlight hours and tonight it's foggy. Better turn on the bicycle light. Of course the glass is blackened somewhat so there is only a glimmer of light. It does not help much to see the road but prevents anyone bumping into you. Whoops! there I've done it. Must have got my front wheel too close to that bank at the side of the road. Turned me for a "flop" in nothing flat. Yes, I'm alright but I took the knee out of this slack suit. You can laugh, guess I did look funny. But let's get moving or it will be pitch dark before we get 'home'. Did we just get up from tea? Here is supper ready and is it good! After all we've ridden six miles!

Sunday eyening — quiet and still. We can put on one of the few silk dresses we possess with high-heeled slippers and gather in the Recreation Hut for our Sunday evening concert. It seems to be Bach this time — recordings you know — and Tchaikowsky's Fifth. Our old dog Toby loves to come in and lie on the rug. He is content if there is good music but just let a radio blare forth with swing 'stuff' and Toby is up, shaking his head, and is out the door in a minute.

Experiences varied all the way from group singing in the small homes of working people to a tea in London, given by the Royal College of Nursing for nurses from overseas, which was attended by Queen Elizabeth. As she passed from the hall she shook hands with each of us and asked, in her gracious manner, about our trip over and

whether or not we liked England.

The hospital we staffed was essentially for military personnel but we took civilians as well. Old people were there and babies too. As when one of the hospital nurseries in our little city had an epidemic of diarrhea, they transferred a number of babies to us. One of our doctors is a well-known pediatrician at home.

The English are reserved and sometimes distant. But if one approaches them with courtesy and respect for their ways and traditions, you are taken into their hearts and homes and you have as true friends as you've known anywhere. Twenty-six happy months in England left me with a deep and abiding faith in a great and noble people.

Blue Cross to the Nurse's Assistance

In a recent editorial in *The Canadian Nurse* a comment was made that nurses do not take good care of themselves. This is particularly true these days when there are so many demands upon their services. While some nurses receive hospitalization when associated with a hospital or through a special arrangement in their alumnae, many do not have this protection as a part of their working arrangements. Moreover, few private duty nurses are protected against the hazard of unexpected hospital care particularly when they are not in the city where alumnae benefits might be available.

The solution to this vital problem is to be found in the Blue Cross Hospital Service Plans, of which there are eighty operating throughout Canada and the United States, protecting sixteen million persons against the cost of hospitalization whether through illness or accident. Benefits, costs and requirements of these plans vary slightly from province to province and for accurate information regarding the plan in your own community it would be well to make local enquiry.

The Quebec Hospital Service Association benefits are available to all employed registered nurses in Quebec, either through their alumnae, hospital groups, or nursing registries. The applicants must be under sixty-

five to be accepted but have the privilege of continuing to subscribe thereafter up to seventy years of age. To date this Association has given protection to many such groups. Our experience is that nurses are anxious to avail themselves of this coverage. They have come into contact with many individuals and families who have delayed hospital care for fear of the costs involved and, at a later date, have to be hospitalized when an acute condition arises, resulting possibly in a longer hospital stay and additional expense. No matter what our social status may be, hospitalization is always a costly business. In most cases, the expenses present a bigger worry than the actual illness itself. People are often paying their bills long after being discharged from hospital or else they are forced to spend a very tidy nest-egg or bonds which they may have counted on for their old age or time of unemployment. Blue Cross counteracts all this. By paying a small sum monthly or annually, to a common fund, the heavy expense is shared among many.

These plans are operated for the benefit of all. One of their main purposes is to raise the health standard of the community and consequently should appeal very strongly to all nurses.

-AILEEN G. VERRAN

The M.C.H. Sports Program

KATHLEEN CLIFFORD

It has long been thought that an active sports program should be integrated into the curriculum of the nursing school. It is most beneficial to the students' moral, physical and mental wellbeing. Due to problems, which one never finds in other types of schools, it had been felt that there were too many difficulties. These problems which high school and college sports directors do not have to contend with concern rigid hours of duty, classes in off-duty hours, night duty and affiliations. They constitute a major item to be considered when attempting to organize inter-class teams, tournaments and the like.

In September 1944, after a very active tennis season, we held a meeting of the Montreal General Hospital students and discussed plans for organizing a more extensive program for the winter. The enthusiasm of the students was so

great that it was decided to try to arrange definite activities. We were assured of every one's co-operation as we knew it should be part of the facilities available to the student in school. We had many suggestions as to what sports should be included and finally settled on five of the most popular — mainly, basketball, swimming, badminton, ice hockey, and tennis. An executive was formed with a chairman, secretary, a sport representative from each class, and a captain or manager for each sport, giving us a total of thirteen on the committee.

We then had to see what facilities we had for these varied activities. Our own gymnasium was too small for organized games excepting badminton. Fortunately, we were able to obtain the use of a gym floor in a nearby school once a week for basketball; membership tickets were



A tense moment in the basketball game.

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bought for the Knights of Columbus pool enabling the students to swim there three nights a week. The engineering department fixed up our rink on the tennis court with boards, lights, and goal posts for hockey.

The executive met and a schedule was planned. The problems in the arrangement of our program were many and very ticklish. How were we to get the students down from the affiliating schools? How could we keep teams together with the varied rotations, night duty, etc., considering the fact that all of these activities had to be arranged for the evening? Since we have an average of fifty girls on affiliation at any one time it was decided to make one person at each of the affiliating schools our contact, and notices of games and events were sent to her to be posted on the bulletin boards so that all our students could be aware of what was taking place. Nurses on night duty often asked for their night off so as to take part in the monthly swim meets or the big basketball game. Needless to say the personnel of each class team was never the same for two successive games which after all was perfectly alright and what we wanted, as the main reason for the whole plan was to give as many people as possible exercise, not just winning cach game. I must add there were a lot of questions asked by the class sport representative as to the whereabouts of her best player if she were not presentonly to find she had started her night duty period.

An outline of the various activities undertaken, prepared by the sports captains, follows:

Badminton:

The gymnasium is open every night and so far there has been a fair turn-out. The hospital has supplied badminton rackets and birds, for those who have not their own. To make the sport more interesting a tournament has been drawn up. The graduates on the staff and the dietitians of the hospital are also taking part in this tournament. Competition is very keen. Inter-class tourna-

ments are also on the program, and we do hope to challenge outside hospitals and maybe some of the city clubs. (Hilda Motherwell).

Tennis:

Twenty-six girls took part in the first tournament of women's singles, and the courts were filled with revived night nurses in the fresh mornings, and the energetic day staff in the evenings. The champion was presented with a racket of her own choosing by the president of the hospital, Mr. Ogilvy. We joined in a friendly game with the Homoeopathic Hospital during midsummer, and enjoyed ourselves immensely. Our annual tournament with the Royal Victoria Hospital nurses came at the end of the season, and although it was rather cold a lot of fun was enjoyed by all. We are looking forward to an equally successful time in this sport next year. (D. Conroy).

Hockey:

At first the suggestion of a hockey team met with much scepticism but now plans are being made with true Canadian zest. Our goal nets and posts are being provided from the hospital workshop. Players supply hockey sticks and other minor equipment. We have enough players enrolled to form four or five inter-class teams. Nurses wanting to play range from figure skaters to volunteers for the position of goalie. There are also a good number of students who have played before. Our schedule consists of inter-class games inter-hospital games and, if we prove to be good enough, we hope to challenge the housemen of the hospital. (M. Findlay).

Basketball:

We were able to secure the gymnasium one night a week at a school situated quite close to the hospital. There we found a well-lighted and well-equipped play room with a courteous and friendly janitor in attendance. An average of twenty-five nurses were present each night and seven teams were organized. The program for the first session closed in December, the winning team to receive a trophy. After Christmas it is proposed to form a hospital team so that inter-hospital matches can be arranged.

(E. Lisson)

Swimming:

The inclusion of swimming in the sports calendar was made possible when sixty inter-changeable memberships were obtained at the Knights of Columbus pool for three nights of every week. Willing instructors do much to encourage the beginner and help the more professional swimmer or diver to perform her art more gracefully. Much unknown talent is being revealed. Monthly meets are held and courses leading to the Bronze medal in life saving are top hits.

(Romayne Royston)

We were very fortunate in attaining our goal so easily. When we first tackled the task of organizing, the case seemed hopeless but with perseverence and patience, the excellent help and wise advice of the principal of our school, many of our headaches were eliminated.

In conclusion may I add that in every activity the enthusiasm runs high. We are so pleased to see the students coming

out for the relaxation afforded them by the exercise and the rivalry between the different classes causes non-players to turn out to root for their own classteam. We have many plans which we hope to carry out this winter, such as a sleigh drive, ice carnival, ski-party, and fancy swimming exhibition. We hope to have a banquet sometime in May to finish off the season to present the prizes won by the classes and individuals.

One must always remember that the education of the student comes first and that the athletic program is, at present, but an extra-curricular activity, but I do hope that in the near future it will be integrated into the school curriculum and be a must for every student in the school.

The Cambiae Mosquito Comes Back

In former issues of the Rockefeller Foundation Review an account has been given of the successful campaign in Brazil against the dangerous malariacarrying Anopheles gambiae mosquito whose home is in Africa. After high death rates and enormous suffering, and with great labour and cost, it can be said with confidence that the gambiae species was eliminated from Brazil.

The Foundation was therefore disturbed to receive, during 1943, advices from its representatives in Rio de Janeiro that gambiae mosquitoes, some of them alive, had been found on planes coming from Accra and Dakar in Africa to Natal. Even more disturbing was the news that five live gambiae had been discovered in dwellings near the Natal airport. Incoming planes from Africa are, of course, fumigated both before they leave Africa and before they land in Brazil, but a few mosquitoes were evidently able to stow away safely in the

modern, complicated airplanes. When it is realized that a single fertilized gambiae could start a conflagration similar to that which swept north from Natal in the thirties, the danger of the situation becomes apparent.

Thanks to the efforts of the Brazilian and United States authorities, the immediate situation is now in hand. But it poses a problem of larger significance which cannot be evaded. Around the ports of Africa and deep within the hinterland lie the breeding centers of the gambiae. The safety of the Western Hemisphere, which is now within a few hours' flight across a narrow ocean, can no longer be left to the uncertainties of a flit-gun campaign. Modern airplane travel has made old methods and ideas of quarantine completely obsolete. If the Americas are adequately to be protected, the breeding places of gambiae, wherever in Africa or elsewhere they may be found, must be eradicated. The campaign must be carried to the sources of infestation. It can no longer be defensive; it must be offensive.

But the problem, of course, is far broader than gambiae. This newly made world which the airplane has tied together has lost its frontiers. Certainly in the field of public health they no longer have significance or meaning. No line can be established anywhere in the world which confines the interest of any one country, because no line can prevent the remote from becoming the immediate danger. Whether it is malaria or yellow fever or typhus or bubonic plague or whatever the disease may be, the nations of the world face these enemies of mankind not as isolated groups behind boundary lines but as members of the human race living suddenly in a frightening propinquity.

Public health can no longer be thought of exclusively in national terms. Whether we like it or not, our technologies now confront us with inescapable demands for a new approach. Some kind of regularized international cooperation is essential. Whatever we may think of the League of Nations, its Health Organization blazed a new trail in the international attack on disease a trail that must be widened into a firm road. Certainly a service of epidemiological intelligence covering the whole world is an immediate necessity, and many other essential public health activities not only lend themselves to collective approach but can be effectively handled only by that method.

In relation to great scourges like malaria and influenza — as indeed in relation to many other perils — nations today are roped like Alpine climbers crossing a glacier: they survive or perish together.

In 1925, after an extensive survey by a commission sent out by The Rockefeller Foundation, a laboratory was built in Lagos, West Africa, for the study of the epidemiology of yellow fever and its relationship to the yellow fever of South

America. It was in this laboratory that many of the tangled threads of the story were unraveled. It was here, too, that tragedy struck, in the death, through yellow fever, of four brilliant scientists, Dr. Adrian Stokes, Dr. Hideyo Noguchi, Dr. William Alexander Young and Dr. Theodore B. Hayne. They gave their lives — as others did in the Americas in an attempt to discover the secrets of this dread disease. As we look back on the progress that has been made in twenty years in increasing our knowledge of yellow fever and arming us with tools to control it, we can truly say these men did not die in vain.

When these pioneers started work in Lagos, no protective vaccine had been developed, no laboratory animal susceptible to the disease was known, no viscerotomy method for diagnosis had been devised, no blood tests to determine immunity had been evolved. Moreover, the whole epidemiological concept of the disease, particularly the idea that the Aedes aegypti mosquito was its only carrier, was based on foundations which experience and experiment were to prove unsubstantial.

The laboratory at Lagos was abandoned in 1934. It was felt that its work had been done and that other centers could more effectively carry on the research. Because an immunity survey had shown the previous presence of yellow fever in vast sections of the country, all the way from Nigeria eastward to the upper reaches of the Nile, a new laboratory was opened in Entebbe, in Uganda, in 1936. Since that date, this laboratory has been the center of research in yellow fever in Africa, while the New York laboratory and the South American institutes have carried the responsibility in the Western Hemisphere.

But in 1943 it was decided to reopen the Lagos laboratory. The buildings are still standing, and personnel, both American and British, has already been assigned. This laboratory will serve as a center for distributing yellow fever vaccine to troops and settlements in West Africa and will constitute a consultative service to the government authorities in the British colonies of Gambia, Sierra Leone, the Gold Coast and Nigeria, where yellow fever has long been endemic. Moreover, there are still puzzling questions about this disease for which answers can be found only in a laboratory.

The most striking difference between vellow fever in Africa and yellow fever in South America is that in the former continent it has not yet been possible definitely to prove the existence of the "jungle" type, since in Africa no rural area has yet been found from which the Aedes aegypti mosquito is absent. To be sure, suggestive evidence of the presence of jungle yellow fever has been obtained by workers in the laboratory in Entebbe, who have isolated the virus from wildcaught mosquitoes other than aegypti. One of the main objectives of the new program centering at Lagos is to find out whether the jungle variety discovered in South America has its counterpart in West Africa. If this proves to be the case, studies will be made there of the mechanism by which this form of vellow fever is transmitted to man, and this research will be tied in with similar research which is now going forward in South America.

The return to Lagos has a certain symbolic interest for The Rockefeller Foundation, for it was in West Africa, in 1927, that a blood specimen was taken from a black native named Asibi who was sick with yellow fever. This specimen was inoculated into a rhesus moneky which had been received from India. Asibi recovered, but the monkey died of the disease. All vaccine manufactured since 1937, both by The Rockefeller Foundation and by government and other agencies as well, derives from the original strain of virus obtained from this humble native. Carried down to the present day from one laboratory animal to another, through repeated tissue cultures and by enormous multiplication, it has afforded immunity to yellow fever to millions of people in many countries. Wherever today in yellow fever areas the armed forces of the allied nations are stationed, they are protected from the disease by vaccination from this same strain. Through the creative imagination of science, the blood of one man in West Africa has been made to serve the whole human race.

-The Rockefeller Foundation Review

News from Greece

(Editor's Note: Miss Jean E. Browne, national director of Junior Red Cross, sent us the following letter received from Captain A. L. Kerr of the R.C.A.M.C. stationed in Greece. We are sure the Old Internationals in Canada will be interested to hear that Miss Messolora is alive and well).

Whether this letter reaches you or not will be a fair test of the postal services. Before passing on the message which I have for you, I had better explain. Having come to Greece a few weeks ago with the Bri-

tish parachutists, to which I am attached as a Medical Officer, I was visiting the Red Cross Hospital in Athens, as part of my off duty sight-seeing. Along with some English doctors, I had gone to watch Professor Maceas, their senior surgeon, operating. Realizing that I was a Canadian Miss Messolora, who had interpreted for us, asked me to write to you. Since civilian mail services have not started yet, I asked what message she would like to have passed on to you, and promised to do my best to return any news to her that you sent in reply.

Her message reads: "To Jean Browne and the Old Internationals in Canada — happy thoughts from a free Greece after long suffering, from C. J. Messolora and the nurses of Greece — and recognition for all done for us by the Canadian people". She asked to be remembered to all her friends, not all of whom she could name.

The gratitude of the citizens here can hardly be expressed in words for the help during this war from the Canadian Red Cross. So many have told me the same story, of how they could not have kept going without that help. These are people well worth

befriending, for one can see at once how much they have tried to help each other. Of our own casualties, most, at first, were nursed by Greek women, who treated them as their own, and who were broken-hearted when I evacuated them later on to a hospital. One man, who was being looked after by an aged couple, complained of a cough, and thoroughly enjoyed the old-fashioned "cupping" which was applied. I think my daily visits were looked on as an interference in their daily nursing routine! I shall try to pass on your news either directly or indirectly to Miss Messolora.

Noted in our Exchange Journals

After very careful study by the Nurses and Midwives Registration Board of New Zealand, their solution to the problem created by the large number of nurses aides has been given official sanction. Their plan provides that if these aides can satisfy the Registration Board that they have "performed not less than six thousand hours of nursing duties, during a period of not more than four years, in not more than four institutions approved by the Registration Board" they may apply to take the prescribed examination for Nursing Aides. These applicants must hold recognized certificates in home nursing, first aid and hygiene as well as evidence of having had a period of sixty hours training in a hospital such as meets the Board's requirements. Those who are successful in passing the examinations "will have the recognized status of Nursing Aide and their names will be recorded on the registrar; many positions in hospitals, other than training schools, will be available for them, and in a sphere of work in keeping with their knowledge and under the supervision of trained nurses, they will fill a useful place in the nursing world". For those more youthful applicants who may wish to qualify as registered nurses, "the nursing aide certificate will entitle them to a credit of one year of that training".

The Nursing Journal of India records editorially the difficulties that have to be met in securing a sufficient number of prospective student nurses. "As yet education of women in India has not advanced to the

place where it is possible for us to get enough students to produce the number of nurses we need if we insist on the educational requirements held today by our better schools or even those held by our nursing councils as their requirement". Rather than accept the alternative of lowering the present standards it is suggested, as a temporary measure, to have two standards of nurses. "One of these groups would be the finest nurses we can make out of the finest student material India can supply . . . The second group would be drawn from the much larger group of young Indian women who finish middle school, but cannot go on with their general education . . . They will greatly extend the nursing care it is possible to provide".

The South African Nursing Journal carries the report of the inauguration of the Block System in two of the schools of nursing. "Under this system the students' ward work and lecture room study are entirely separated. The student nurse has no long hours of study when on ward duty, and the strain and responsibility of nursing is removed when concentrating on theoretical study".

To meet the situation created by the war demands for nurses aides who may wish to enter upon their training to become fully qualified nurses, South African nurses secured authority to grant "three months for every year of military nursing up to a total of twelve months" In other words, up to a year may be deducted.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

Nurses of Great Britain Point the Way

A recent issue of the Nursing Times carries a leading editorial on the appointment of an Advisory Board on Nursing Education to the Council of the Royal College of Nursing. Prominent and leading educationalists from the field of general education are among the members of the Board.

The object of the Council in settling up this Board is to ensure that nursing education is recognized as education and benefits by the advances in educational methods and facilities which are characteristic of present developments. We used to speak of the training of the nurse, stressing rather the practical art than the scientific basis on which the practice should stand. The Council speaks of education and training; in fact, this was chosen as the title of one of the most important sub-committees of the Horder Committee. It is essential for the future of nursing that both during her professional education, her preparation for it and her post-certificate education, the nurse benefits by help and advice which are both educationally sound and professionally appropriate. The Board, bringing together as it does both specialists in general education and specialists in the professional field, will ensure a greater recognition of and a greater contribution to nursing education from other fields, so that those who know about nursing have the assistance of those who know about education.

Committee on Legislation

The first draft revision of the Constitution and By-Laws is underway. This will be sent to all Provincial Associations for their official consideration regarding (1) its legal relationship to each Provincial Act, and (2) its adaptability for effective functioning of professional interests.

The committee will need all the suggestions and help which the Provincial Associations can contribute if the revision is to fill the needs of both the provincial and national associations.

Committee on Labour Relations

Following a resolution submitted by one of the Provincial Associations relating to a special request to the Federal Government made by the Society of Professional Engineers who were seeking for a definition of their standing in regard to P. C. 1003, the Canadian Nurses Association sought the advice of its solicitor as to the status of nurses and were informed that no immediate action by this Association was necessary. In the meantime, however, the Engineers' Society has proceeded with the drafting of a proposed Order-in-Council which will cover the problem of collective bargaining so far as professional workers are concerned.

Legal advice was again sought by the

Canadian Nurses Association as to the advisability of preparing a brief for submission along with that of the Engineers' Society. The solicitor advised against taking any action in this regard. He did, however, recommend:

That each organization employing two or more nurses be required to have the authorization of at least 50 per cent of their nursing staff to secure authorization for their Provincial Association to act as their collective bargaining agents.

The labour relations committee feel that with the frequent turnover in nursing personnel this might lead to considerable confusion and, therefore, this matter should be given considerably more study by both national and provincial associations.

Donations to British Nurses Relief Fund

We gratefully acknowledge donations from the following Provincial Associations to the British Nurses Relief Fund: British Columbia, Mary Campbell, \$4.00; Penticton Chapter, R.N. A.B.C., \$20.00; Princeton Chapter, R.N.A.B.C., \$15.00; Cowichan Chapter, R.N.A.B.C., \$6.20; Vancouver General Hospital Alumnae, \$600; Kamloops-Tranquille Chapter, R.N.A.B.C., \$20.00; Alberni Chapter, R.N.A.B.C., \$50.00; Total \$715.20.

From the Registrar of the Registered Nurses Association of the Province of Quebec comes the following: "We are pleased to enclose herewith cheque for \$1,000., being a contribution towards the British Nurses Relief Fund. Although no particular publicity was given to this fund for over a year, the money was subscribed by the same members of the Registered Nurses Association of the Province of Quebec who continue to do so regularly."

Short-Term Bursaries

Nurses are reminded that applications for short-term bursaries can be received in the provinces until March 1, 1945. They must be in National Office for the consideration of the national committee not later than March 10, 1945 and any short-term courses taken on 1944-45 bursaries must begin not later than June 1, 1945.

Data and Summary Report

The accompanying table shows distribution of student nurses for 1944 according to year-in-training, with the 1943 comparative figure in Grand Total only.

Supplementary information from a variety of sources enables us to make a further statement regarding the student recruitment returns:

- 1. The majority of schools of nursing have reached the maximum in housing accommodation.
- 2. In October, 1944, the replies from the provincial secretaries indicated that full classes of students had been enrolled in virtually all schools. The greatest difficulty in securing students is being experienced by the very small schools, while the larger schools still have a waiting list of applicants.

Social Hygiene Day

On February 7 Canada observed its second annual national Social Hygiene Day sponsored by the Health League of Canada, in co-operation with the federal and provincial departments of health. The day was set aside to re-focus attention on the Dominion's No. 1 public health problem. Through such obser-

Data and Summary Report on Student Nurse Enrolment in Schools of Nursing in Canada as of November, 1944

Province	Probat- ioners	lst Year	Probs. & 1st Total	2nd Year	3rd Year	Grand 1944	d Total 1943
P.E.I			36	38	27	101	93
N.B	136	172	308	158	98	564	531
Alberta	213	111	324	296	325	945	956
Ontario	1170	691	1861	1220	1292	4373	4024
Quebec EnglishFrench.	174 349 — 523	121 509 630	295 858 1153	252 575 — 827	292 401 693	839 1834 2673	2182
B.C	231	211	442	348	342	1132	1124
N.S	170	142	312	201	224	737	712
Sask	208	126	334	286	258	878	848
Man	195	106	301	281	269	851	889
TOTALS	2846	2189	5071	3655	3528	12,254	11,359

vance it is hoped to reinforce public interest in the never-ceasing fight waged by various governmental agencies federal and provincial — and voluntary agencies led by the Health League.

Canadians were asked to take their place in the four-sector fight against VD—the four sectors being health, welfare, legal and moral. It was stressed that the outcome of the battle against these insidious diseases is of vital importance to the Dominion's war effort and the welfare of post-war Canada. Venereal diseases bring devastating results—dependency, stillbirths, sterility, blindness, invalidism, mental deficiency and mental diseases, the breaking up of homes, divorce—and death.

The nurses of Canada are reminded

once again of the resolution which was passed unanimously at the biennial convention of the Canadian Nurses Association last summer:

Whereas the stresses and strains of war have aggravated the already serious situation in regard to the control of venereal diseases in Canada, and whereas the recognized leaders in this field have made preparations for a national campaign of education and extension of diagnostic and treatment services in order to rid this country of the venereal diseases, and whereas registered nurses in all fields of service can and should play an important part in this work of vital importance to the health and happiness of the people of Canada; therefore be it resolved: that the Canadian Nurses Association pledge itself to do anything within its power to promote the forthcoming campaign.

Preview

Clinical instruction has become an exceedingly important part of the teaching program in our schools of nursing. Mary

Eichel has outlined the application of the principles of clinical instruction to the training received in the operating theatre.

Interesting People

After sixteen months as assistant executive secretary in the National Office, Canadian Nurses Association, Florence Harriet Walker has accepted the position of associate secretary of the Registered Nurses Association of Ontario. She entered upon her new duties in the middle of January.

A native of Ontario, Miss Walker received her preliminary education there and graduated from the School of Nursing of the Hamilton General Hospital. A prize awarded by the Board of Governors enabled her to take post-graduate study in teaching and supervision at the School for Graduate Nurses, McGill University. She returned to her home school as instructor for three years then moved out to British Columbia, serving in various capacities on the staff of the Vancouver General Hospital. During her stay in Vancouver, she undertook further study at the University of British Columbia leading to the degrees of B.A. and B.A.Sc. (nursing).



Hubert Beckett FLORENCE H. WALKER

Throughout her months at National Office, Miss Walker carried much of the responsibility for the administration and distribution of the funds from the Federal Government Grants. Her sound knowledge of Association affairs and her general interest in all that concerns nursing will make her a valuable asset to the Ontario Association. She is an indefatigable worker, conscientious and painstaking, yet keenly interested in the world of music and of literature. Miss Walker's headquarters will be in Toronto.

Through the kind co-operation of the Winnipeg Board, Adella McKee is being released from her position as district superintendent of the Winnipeg Branch and will be attached to the staff of the National Office of the Victorian Order of Nurses for Canada for a temporary period.

A graduate of the Brantford General Hospital and of the course in public health nursing, University of British Columbia, Miss McKee first served with the Victorian Order as a staff nurse on the Calgary Branch, then for a year was in charge of the branch in Saskatoon. Following this, Miss McKee returned to Calgary where she supervised the service for three years. Eight years ago she was appointed to the Winnipeg Branch as district superintendent, which position she has filled successfully.

Miss McKee has an engaging personality and genuine interest in people. She has made many friends not only for herself but also for the organization she serves. During Miss McKee's absence, the nursing service in Winnipeg will be in charge of her assistant, Lynette Gunn, and we have every confidence the work will be well carried on under her direction.

Christine Elizabeth Charter has recently been appointed assistant district superintendent of the Vancouver branch of the Victorian Order of Nurses after

INTERESTING PEOPLE

serving in various capacities with the Order in Halifax and Liverpool, N.S. and in Toronto.

Miss Charter who claims to be English "with a bit of Scotch", received her academic education in England and New Brunswick. She graduated from the School of Nursing of the Saint John General Hospital. After taking a postgraduate course in obstetrics at the Royal Victoria Hospital, Montreal, she received her diploma in public health nursing at the School of Nursing, Toronto University.

For recreation, Miss Charter enjoys reading and music. She is very much interested in handicrafts also.

Josephine De Brincat, who is serving as a public health supervisor with UNRRA, has served with the Manitoba provincial health department since her graduation from the Winnipeg General Hospital in 1925. In 1942, she took a special course in industrial nursing at the School of Nursing, University of Toronto, following which she returned to Manitoba as consultant in industrial hygiene. Miss De Brincat was born on the historic isle of Malta and is an accomplished linguist in both French and Italian.

Agnes D. Carson was honoured in a presentation at the Saint John Tuberculosis Hospital in November when she observed the fiftieth anniversary of her graduation. Born in St. Andrews, N.B., of Loyalist descent, Miss Carson entered the training school of the General Public Hospital in Saint John in 1892. In 1895, she went on duty as the first district nurse of the city of Saint John at a sal-



Hudson's Bay Co., Vancouver CHRISTINE E. CHARTER

ary of \$175 a year! After a brief period, she went to the New York Polyclinic Medical School and Hospital where she was superintendent of nurses until 1913. In that year she moved to Detroit to organize and superintend the Home Nursing Association.

After nine years in Detroit, Miss Carson returned to Canada and for seven years was in executive positions in hospitals in Halifax. Her professional work was interrupted for two years by home responsibilities, after which she joined the night nursing staff of the Saint John Tuberculosis Hospital where she is still on duty. Miss Carson is highly esteemed and greatly beloved by both her associates on the staff and the patients.

Miss Carson has always maintained an active interest in the work of the nursing organizations. She has served as president of the Halifax Branch of the R.N.A.N.S. and also of the Saint John Branch of the N.B.A.R.N.

A Tribute to a Gentle Lady

When the news of the sudden death of Miss Nora Tedford reaches the four corners of the earth, there will be doctors and nurses in each of them who will experience a feeling of personal loss for this gentle little lady was known and greatly loved by many in all lands.

As a member of the 1895 class of nurses of the school established by Miss Livingston in The Montreal General Hospital, Miss Tedford demonstrated marked talent and ability and was the first qualified graduate nurse appointed "in charge" of the surgical operating rooms, a position she held with great

THE CANADIAN NURSE



Rice, Montreal NORA TEDFORD

dignity for twenty-two years, during which time hundreds of student nurses learned of the mysteries of surgical technique and service from one who was a past master of the art, and of teaching method.

To those of us who learned to know of her hobbies and interests. Miss Tedford became a true and valued friend. Aside from the work of her choice, Miss Tedford found time to contribute to several pioneer nursing projects, chief among which was the establishment of the Mutual Benefit Association of her alma mater, which owes its inspiration to her alert brain and untiring efforts and regarding which she carried with marked efficiency the office of secretary-treasurer for its first five years.

Recorded in the history of the Canadian Nurses Association on page 13 is the following:

"Miss Nora Tedford of Montreal has left on record a graphic account of the proceedings of the Congress of the International Council of Nurses held at the Church House, Westminster, London, England, July 19-24, 1909."

The graphic account referred to follows and provides enjoyable reading. Miss Tedford was always proud of the fact that she had been included among the five official delegates who represented Canadian nurses on such an auspicious occasion when the Canadian Nurses Association, known at that time as "The Canadian National Association

of Trained Nurses", was received into membership in the International Council of Nurses and that she carried the responsibilities of official secretary.

Miss Tedford appreciated and loved good music, one of her greatest joys in life being the love of her talented brother "Jack" (J. Leslie) who was for years Montreal's leading tenor. To watch her during the expert rendering of the Tannhauser Overture was a thrilling experience.

During the old surgical operating room days it was equally inspiring perhaps, to see her lay down her tools at the close of a big day in the theatres when she would then perch her tiny self on a high stool and execute the most fascinating needle-work. She loved the birds and flowers and knew more about botany than many an acknowledged teacher of that fascinating subject.

Miss Tedford was a charter member of the Alumnae Association of her school, for the organization of which she was to a great extent responsible, and in recognition of her services towards it the Alumnae bestowed upon her an honourary life membership of the Mutual Benefit Association.

Following her retirement from active duty several years ago, Miss Tedford decided to thoroughly enjoy freedom from responsibility, and she slipped away suddenly on January 5 at the age of seventy-five years.

-E. FRANCES UPTON.

Obituaries

Sister St. Viateur died recently at the Motherhouse of the Grey Nuns of the Cross in Ottawa. A member of the Class of 1907 of the Ottawa General Hospital, she served continuously in various departments of the hospital until ill health forced her to relinquish her duties four years ago.

Mrs. George Reid (Beatrice MacLeod) died recently in Pittsburg, Pa. Mrs. Reid was a graduate of the Prince Edward Island Hospital and a member of the Class of 1931.

STUDENT NURSES PAGE

Occupational Therapy for the Mentally III

ALICE L. Rosse Student Nurse

School of Nursing, Ontario Hospital, Hamilton.

The importance of scientifically planned and directed occupations for those suffering from various types of psychoses and neuroses, as well as for the patient whose disabilities are physical, is becoming increasingly apparent. The role of the trained occupational therapist is familiar to all who work with mental patients. However, it is questionable whether the nurse, graduate or student, realizes fully her own responsibilities and opportunities for service in this field.

Most of us who receive our training in mental hospitals are given a course in the theory and practice of occupational therapy, an interesting and fascinating study. In the press of other duties perhaps we do not apply these teachings as we might. To-day, due to the demands of the armed forces, the number of occupational therapists available for hospital work is limited. It is, therefore, a challenge to the nursing staffs to see that their patients do not lack the benefits of this form of therapy.

The nurse sees her patient for much longer periods and is in closer contact with her than is the therapist. She is in a position to suggest and supervise activities and occupations and can see how the patient reacts to these. Trained to be observant and to report her observations promptly and accurately, she can be of

great assistance to the medical staff in the plan of treatment, as even a simple task, satisfactorily accomplished, is of importance. Such details as a properly made bed, or a well-swept room may be the first steps forward for a disordered mind. The supervision of the patient and her training in habits of neatness, cleanliness and self-reliance are a vital part of the mental nurses' duties; however it should not be forgotten that helping with her sewing, knitting, etc. is a no less essential aspect of her work.

Naturally a complete knowledge of the use of colours and fabrics, the teaching of basket work and the mastery of the hand loom, which are all in the trained occupational therapists' field, are far too ambitious and time-consuming for any busy nurse. Frequently, however, the therapist can be on each ward for only a short period every day, or she may visit them but once or twice a week. In the interim, the nurse who can turn the heel of a sock, decipher a crochet pattern, or assist with embroidery stitches, is indeed extending her ministrations to the fullest. The convalescent mental patient may easily lose interest and slip back if unable to proceed with a piece of handiwork, because she got into difficulties with it. Encouragement and kindly skilled help are much appreciated and fully repay the nurse for the

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extra time and patience she may expend.

It must be remembered that in some occupations, for instance sewing, or the making of scrap books, there are certain hazards. A nurse with many duties cannot always take the responsibility of giving out scissors, etc. There are, however, many things, which, if one is intelligent and enterprising may be safely utilized as occupations. The use of plastic knitting needles entails little risk and

the making of belts and other novelties of torn and folded strips of coloured scrap paper can be interesting when well directed. Even the provision and supervision of indoor games is beneficial.

Knowing that by increasing her interest in and applying her knowledge of occupational therapy she may further the recovery of her patients, the nurse in mental hospitals should be stimulated to greater efforts in this sphere.

We had a Campaign!!!

NATALIE HARDING
Student Nurse

School of Nursing, Homoeopathic Hospital, Montreal

A campaign is defined in the dictionary as, "the period during which an army carries on active operations in the field". This is exactly what happened at the Homoeopathic Hospital in Montreal recently. The army was our student nurses and the result of the active operations was an exceptionally high percentage of subscriptions to *The Cana-*

OVNEO AND PUBLISHED

Model use in the exhibit.

dian Nurse Journal by the student nur-

A list was posted with the names of the students arranged in classes. As each nurse subscribed to the magazine, she was awarded a star beside her name. The subscriptions poured in as enthusiasm mounted and the competition began. The campaign came to a thrilling climax when the editor gave the students an extremely interesting talk on her work with the *Journal*, at the regular monthly meeting of the Student Association.

The nurses then gave a very original skit. The scenery was composed of a huge book designed to represent the Journal. Large wooden frames were covered with white sheeting and arranged as leaves of a book. The outer page was illustrated by a replica of that familiar blue and white cover, and the other pages were marked with huge black letters presenting the different sections of the Journal. A student nurse gave the introduction to the skit, and as she opened the book and turned the pages, out stepped other students who

read articles which they themselves had prepared on the various sections of the *Journal* they represented.

Was our tour of operations successful? Why, the very fact that the students not only subscribed whole-heartedly to the *Journal* but that they realized

what valuable and most interesting knowledge *The Canadian Nurse* offers, was proof of its profitableness.

Here's a challenge now, you other armies of student nurses! Why not try out a campaign to raise your subscription level to 100 per cent?

Letters from the Alaska Highway District

August 10, 1944. There is nothing small in the Yukon Valley - day after day down stream, towering mountains, big islands, etc. I left Whitehorse on July 26 and reached Dawson after two nights and two days spent five days in and around town, visited the Indian village of Moosehide, the hospital and hostel. Coming back up-stream is slower. The Yukon waters are very swift, and I travelled on a smaller boat to Selkirk arriving on Saturday. All the Indians were outof-town for the weekend fishing, so after morning service on Sunday we all went in a small motor boat to the mouth of the Pelly river, and to a damned-up pool where the sunshine warmed the water. There we revelled in what a little girl called a hot spring - we did not think it 'so hot' and it was also muddy. We drank copious quantities of coffee and had a couple of soup-bowls apiece of ice cream, which the men made upon arrival on the island.

Monday morning the R.C.M. policeman and I set off up-stream in a small motor boat for Minto, where a band of Indians were gathered. The twenty mile trip in the open boat took almost four hours, and one sees the beauty of the islands more intimately at close range. After gathering the Indians at the old roadhouse, built to accommodate the '98'ers, the policeman listed the people and prepared their arms while I vaccinated them and gave the first of two doses of alum precipitate toxoid for diphtheria. This, of course, needs only two doses, and I go back again in six weeks. An old man who has lived at Minto since the days of '98 (and keeps a dirtier house than most of the natives) prepared a meal for us. He boiled potatoes, grown in his own garden, and opened a can of Prem, and we had to eat.

The following day we travelled up the Pelly river about fifteen miles. Here we had no building in which to work. A wooden box was brought out and covered with paper towelling. I placed my sterile cover with syringes, etc. on it, with an alcohol lamp sheltered by a bottle of pills in one corner. Above our heads stretched a piece of canvas sheltering some poles on which hung whole filleted salmon at one end and the complete vertebrae and tails tied in bundles at the other. In the centre was the usual fire of smoke to keep away the flies; this was a great help, only just as we commenced operations the wind changed and we were in the line of fire, or rather smoke. The children ran away and we thought they had gone to hide, so were amazed when they returned and stood before us with hands and faces washed and clean print dresses on. On the third day we worked on the natives, who had by this time returned to Selkirk. Here we had a clean school-room and did everything in the orthodox manner. Quite a number of white people were vaccinated

The trip up-stream has been of intense interest, so much to see when we travel at slower speed. Five Finger Rapids, "Cape Horn" (a very dangerous corner to navigate), and so much more I could tell you about, but it would need to be seen to be appreciated—mountains, valleys, creeks, streams, rocks, basalt, volcanic ash, sand, wood-camps, and fishing stations.

Yesterday afternoon we stopped at a large wood-camp at my request. The local Anglican missionary came ashore to help me and two volunteers from among the passengers. We went into the wood-cutters' cabin — fairly clean and tidy (one room with every-

thing in it). We started a wood fire to provide boiling water for the needles. On the kitchen table we spread our supplies and gave the first dose of toxoid and vaccinated all the natives. The help was all 'green' but very willing. The state of these people is pitiable in the extreme; so much needs to be done for them and it is going to take a lot of careful planning for their future health. There are so many bands, so widely scattered and they vary so in intelligence and in cleanliness or filth,

August 20, 1944. Am writing you from Ross River - it is east from Selkirk on the Yukon river and north from Johnson's Crossing. To reach it I came along the Highway to Johnson's Crossing and north from there 141 miles. It was a hurried preparation, my medical supplies were ready, but clothes had to be left till the last minute as they crease so in a gunny sack. We travelled sometimes at fifty miles an hour, sometimes at five and averaged thirty-three. The countryside is something like the White Mountains or Adirondacks. (Interruption - an American Army youngster came to my tent with a couple of bars of chocolate for a chat; poor kid, from the Bronx, New York City, wanted to know if I wasn't lonely in this awful country. I told him to gather some wood and bring some of the other boys, and we would have a bonfire by the water and a sing-song at 8 p.m. They have nothing to do to keep out of mischief in an Indian village).

To go back to my story, we arrived at the ferry at the Pelly river where the Ross river empties into it and found the ferry on the other side and no one around. There was a wooden foot bridge with steel cable suspension supports, and my driver walked across while I sat and drank in the scenery. It was different; the river valley is broad, with tall spreading willows, good soil, and the very high hills covered with pale green, grassy moss; the soil erosion of centuries makes queer formation along the Pelly. Across from the flats on which the trading-post and village are built there is a very high plateau, which looks to me like lava from a volcanic eruption; there are evidences at other places but this is quite different from anything I have seen anywhere. The whole scene, viewed from the other side where I sat, looked like a tremendous, futuristic painting in pastel shades.

We reached camp in time to meet the men coming out from supper, but there was

still cod with shrimp sauce, potatoes, beans, coffee, and pie left. I am used to eating in these camps now, wooden benches with tables attached as at picnic grounds, everything on the table, and all help themselves, cup and plate, knife, fork and two spoons. They found an extra plate for my pie. We stopped at the store for the key to a supposedly unused log cabin only to find that someone had moved in a month before. There were members of a geological survey in one cabin, and my prospective abode was occupied by their truck driver and his wife and baby. She certainly was glad to see me. Her husband was away till the following day, so two of the men came over with a cot, mattress and sleeping bag, and I was settled for that night. The next morning I walked over half a mile back to the camp for coffee and toast, gathered the Indians into the trading store where I vaccinated them all and put on the Vollmer patch for the tuberculin test. The people are friendly and respectful and welcome the nurse. Down to the trading post this morning and gathered the people to remove patches and found twelve more waiting for me - they had hidden on Saturday and now wanted vaccination and patch.

On Saturday evening some of the geologists had put up a tent for me and I have my cot, sleeping bag, a table, and all my kit in it. The sun is beating down fiercely just now and I am warm, but the nights are frosty and good for sleeping (the tent is covered with frost every morning and my clothes are wet and have to be hung to dry before I can dress). Last night a wolf howled near by and set all the dogs barking and howling, and I had visions of a wolf's nose poking under the tent flap! I am at the far end of the village and few can see me.

Tuesday afternoon the sun was scorching hot as it had been on Monday. Mrs. X and I went for a walk to the Indian cemetery. I had invited three young Indian girls, all newly married, to come with us. As we walked I pointed out edible weeds and explained how to prepare them, also how to prepare rose-hips for jam and jelly and how to make a syrup rich in Vitamin C to take the place of oranges. We found a tidy, well-kept cemetery with so many graves marking the resting-place of young children. There has been no one to teach them how to cook or what to eat but they are so willing to learn.

-MINNIE HACKETT.

The Nurse - a Welcome Sight

"One thing I know" - reports Mrs. Frances Payne Bolton in the January 1945 issue of the American Journal of Nursing, after a two months' visit to hospitals of England and areas of France which have been liberated - "Were I fit and young enough and trained nothing would keep me from meeting the greatest challenge American life has ever given women who are nurses. If I were trained in nursing or physical therapy or as a nurse's aide and unable to go overseas I would apply for service in our hospitals here to which these men of ours are coming by the thousand. I wouldn't miss the experience altogether. I wouldn't go into it just because of the terrible need our wounded have for care: I would do it partly because I know I couldn't face myself in the years that inevitably come, when one looks back on life, if I had let the opportunity to live deeply pass me by.

Recalling her experiences, Mrs. Bolton writes:

"On D-Day plus four the first of our women joined our men on the shores of France for the healing of nations — even as they had joined them in Africa and Sicily and Italy — even as they are with them in India, in China, or the islands of the Pacific and in the unbelievable hospital ships of the air. No wonder a soldier's eye lights up when he speaks of a nurse, no wonder!

First to a well-housed general hospital! Brick buildings that originally held an English hospital with additional Nissen huts to bring it up to the necessary number of beds. The best possible equipment and general facilities, an exceedingly efficient, an exceedingly understanding C.O. and a splendid staff. True, the staff was small, considering the number of beds: something between 1,000 and 1,500 beds, and 50 doctors, 83 nurses, 200 enlisted men; but the difficulty in securing both doctors and nurses forced a general reduction from the original numbers.

Nursing on these particular wards was heavy. Men who cannot move themselves need to be turned and rubbed and turned again every two hours in addition to the regular care their wounds require. Yes, heavy nursing but infinitely satisfying. On

other wards were men with bandaged eves unused to darkness, faced with grim certainty that the only sun that they will ever see must rise in their own hearts; men without legs, without an arm, with terrible body wounds, men with shattered faces, their jaws wired together, sucking their food through tubes. Most tragic of all are the men with broken nerves and shattered minds, lost in the chaos of a destruction they could not withstand. On still other wards were men terribly burned, yet not beyond hope, for the wonderful easement of the hours in the saline tubs relaxes their tensions and brings healing. They are upheld by the promise that when nature has done her temporary best, plastic surgery combined with an infinite patience will rebuild a leg, a hand, an arm, a face so that living a normal and constructive life will become first a possibility, then a certainty.

I shall always remember two lads, one with his right arm in plaster hitching along with one knee on a chair, his foot bandaged, the other with his left hand in splints, the fingers on traction. Together they had a pair of good arms with which they were shaving the ward!

I talked with a soldier one afternoon who was to go home. Lo and behold! At the airstrip a few days later there he was on his litter, his x-rays under his pillow, his little bag of valuables tied on, his eyes shining. A doctor went on that particular plane: there were some pretty sick men aboard that needed to get home. Usually the nurse carries the responsibility alone. Ask the men sometime what they think of those flight nurses!

In France it was all very different, yet curiously the same. My headquarters was a tent hospital that was just setting itself up not very far from the beaches. When I left every bed was filled, every nurse busy. But even then when they were barely established they were awaiting orders to move forward.

That was the amazing quality of our hospitals in France — their fluidity, their motility and the extraordinary quality of service they maintain under these conditions. Always on the move trying to keep up with the Armies! I chased one hospital halfway across France and never did catch up with it!"

FEBRUARY, 1945

Red Cross Bursaries for Undergraduate Nursing Education

At a recent meeting of the Executive of the Ontario Division of the Canadian Red Cross Society, recommendations of the Nursing Committee were adopted whereby for a period not to exceed ten years, bursaries will be awarded to certain young women resident in Ontario who wish to enrol in an undergraduate degree course in nursing or public health nursing or both in one of the universities of the province.

It will be recalled that following the last great war the Canadian Red Cross Society established courses for graduate nurses in a number of Canadian universities including the University of Western Ontario and the University of Toronto. In the interval, nursing education has broadened until a pressing need is for financial assistance to enable promising students to obtain sound basic preparation for posts of leadership in the various fields of nursing. Provision has been made therefore to set aside for bursaries \$25,000 from the peace-time funds of the Division. These will not exceed \$1,000 for

any one student, except in unusual circumstances, and are given in order that candidates with outstanding qualifications may not be denied this preparation if financially unable to meet the total cost involved.

A committee appointed by the Division will award the bursaries and all universities offering a basic training in nursing will be considered. However, certain educational standards will be required of all university schools or departments enrolling such candidates. The Division has stipulated that following a period of internship the student must agree to serve the Ontario Division in some branch of nursing for at least one year after the completion of the course.

In so doing recognition has been given to voluntary service rendered by the nursing profession in the Division's work over a period of years. Moreover, a unique and signal contribution has been made to sound undergraduate nursing education under university auspices within the province.

-FLORENCE H. M. EMORY.

Department of Health and Public Welfare, Manitoba

The following have recently been appointed to the Provincial Public Health Nursing staff: Lucille Crawford (Children's Hospital, Winnipeg), with the Dauphin Health Unit; Patricia Martin (St. Joseph's Hospital), at Grahamdale; Miss McLeod (Grace Hospital), at McCreary; Janet Kennedy (St. Anthony's Hospital), at LePas; E. Radley (Dauphin General Hospital), at Rorketon; Miss Cruikshanks (Neepawa General Hospital), at Flin Flon; Miss Ward (Victoria Hospital), at Fisher branch.

The following have returned to the staff

after taking courses in public health nursing: A. Kennedy (University of Minnesota), at Flin Flon; A. Spence (B.Sc., University of Minnesota), at McCauley; E. Brown (University of Western Ontario), at Brandon; J. Williamson (University of Manitoba), with Dauphin Health Unit. Lilliam Blair, Alexander, has returned to the staff after three years of service in South Africa, where she was stationed at the military hospital at Potchefstroom. Miss Blair is at present with the Division of Venereal Disease Control.

Ontario Public Health Nursing Service

Oleavia Chant (Buffalo City Hospital School of Nursing and University of To-

ronto public health course) has resigned her position at Kirkland Lake and accepted the



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*National Research Council, Reprint and Circular Series No. 115, Jan. 1943.

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MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

FEBRUARY, 1945 139 appointment as public health nurse for Milton, Acton and Georgetown.

Ruth McClure (University of Alberta Hospital School of Nursing and University of Alberta public health course) has accepted a staff appointment with the City of Toronto Department of Health.

Kathleen Harvey and Isabel Petrie (University of Toronto School of Nursing Diploma Course) have accepted appointments as staff nurses with the Porcupine Health Unit.

Mrs. Eileen Bruce (Bretzlaff) (Ottawa Civic Hospital School of Nursing and McGill University public health course) has resigned her position with the Ottawa Collegiate Board.

Edith Horton (University of Western Ontario public health course) has resigned her position with the Victorian Order of Nurses at Kitchener to accept an appointment with the Ottawa Collegiate Board.

Mrs. Marie Chabot (Cloutier) (University of Western Ontario public health course)

is returning to resume her duties with the North Bay Board of Health.

Margaret Penty (St. Joseph's Hospital School for Nurses, Sudbury, and University of Western Ontario public health course) has resigned her position with the Victorian Order of Nurses and has been appointed public health nurse at St. Mary's.

Nancy Craig (Toronto Western Hospital School for Nurses and University of Toronto public health course) has been appointed a staff nurse at Peterborough, having resigned her position in Manitoba.

Essie Kain (Toronto Western Hospital School for Nurses and University of Toronto public health course) has accepted an appointment as staff nurse with the Porcupine Health Unit.

Margaret Turner (Hamilton General Hospital and University of Western Ontario public health course) has resigned her position at Kitchener to accept an appointment with the Wentworth County School Health Unit.

Public Health Nursing Division, Toronto

The following nurses were appointed in 1944 to the Division of Public Health Nursing, Department of Public Health, Toronto:

Graduates of the Toronto General Hospital and University of Toronto public health nursing course: Elizabeth Boulter, Eileen Clark, Beatrice Cryderman, Ina Forrest, Margaret Hallawell, Frances Hayhoe, Margaret Mellon, Lillian Wark, Olive Wood.

Graduates of the Toronto Western Hospital and University of Toronto public health nursing course: Mary Arneil, Edythe Smith, Lillian Taylor.

Graduates of St. Michael's Hospital, Toronto, and University of Toronto public health nursing course: Marie Bedford, Mrs. Pauline McCowatt, Margaret McNamara, Margaret Regan.

Graduates of University of Toronto School of Nursing: Mrs. Dorothy Johnston, Mary Willet.

Eileen Balne (Brantford General Hospital), Helen Clarida (Port Arthur General Hospital), Margaret Coburn (Oshawa General Hospital), Doceil Eldred (Saskatoon City Hospital), Agnes Heffernan (St. Jo-

seph's Hospital, London), Doris Holmes (Hospital for Sick Children, Toronto) Leona MacGregor (Bellevue Training School for Nurses, New York), Alice McGee (Oshawa General Hospital), Mrs. Dorothy Marshall (Montreal General Hospital), Mrs. Edna Querrie (Hamilton General Hospital), Marguerite Saxton naught Training School for Nurses, Weston). (All nurses have taken the public health nursing course at the University of Toronto).

Mrs. Edna McLean (Brantford General Hospital and public health nursing course, Simmons College, Boston), Mrs. Mary Scott (Victoria Hospital, London, and public health nursing course, University of Western Ontario), Nance Cuyler (B.Sc.N., University of Alberta).

The following nurses are now on active service: Phyllis Shannon (with the R.C. A.F.); Margaret Smith, Mary Turnbull, Muriel Wright (with the R.C.A.M.C.).

Resignations have been accepted from Jean McWilliam, Ella Ratz, Mrs. Katherine Robinson.



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FEBRUARY. 1945

Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

Bessie Jackson (Ottawa Civic Hospital and public health nursing course, McGill University) has returned to the Order and is in charge of the newly opened branch in Fort William.

May Jeanne MacKay (General Hospital, Brantford, and public health nursing course, University of Toronto), who was previously on the Toronto staff, has returned to the Order and is in charge of the Brantford Branch.

Helen Keith (Ottawa Civic Hospital) and Clara Weiss (Holy Family Nursing School, Prince Albert), having completed a two months' period of orientation introductory to Victorian Order nursing, have been posted to Liverpool, N. S. and Timmins, Ontario, respectively.

Gwendolyn Angus (Victoria General Hospital, Halifax) has been appointed temporarily to the Halifax staff.

Mrs. Alma Johnson (University of Alberta Hospital, Edmonton), Patricia Merriman, (Holy Cross Hospital, Calgary), and Regina Cowan (St. Mary's Hospital, Montreal) have been appointed temporarily to the Montreal staff.

Ruth Kirkpatrick (Hamilton General Hospital) has been appointed temporarily to the Peterborough staff.

Evangeline Saulnier (King's Co. Hospital, Brooklyn, N.Y.) has been appointed temporarily to the Yarmouth staff.

Annie Wade (Victoria Hospital, London) has been appointed temporarily to the Woodstock staff.

Joan Marchand (St. Luke's Hospital, Montreal) has been appointed temporarily to the Lachine staff.

Emelia Longo (St. Joseph's Hospital, Toronto) has been appointed temporarily to the York Township staff.

Mary Dewar (Royal Victoria Hospital, Montreal) has been appointed temporarily to the Kingston staff.

Irene Redman (General Hospital, Oshawa) has been appointed temporarily to the Oshawa staff.

Betty Brown (Victoria Hospital, London) has been appointed temporarily to the Chatham staff,

Merle Pringle (Winnipeg General Hospital) has been appointed temporarily to the Winnipeg staff.

Alfreda Lavoie (Moncton Hospital) has been temporarily appointed to the Moncton staff.

Helen Elizabeth McQuay (Kingston General Hospital) has been appointed temporarily to the Kingston Branch.

Vera Bruner has been transferred from the Sarnia staff to take charge of the newly opened branch in Kingsville. Hattie Empey has been transferred from the Brantford Branch to the Sherbrooke Branch. Georgina Carr has been transferred from the Lachine Branch to the Woodstock (Ont.) Branch. Dorothy Fullerton has been transferred from the Pictou staff to the Saint John staff. Margaret Rowe has been transferred from the Woodstock Branch to the Cornwall Branch.

Ruby Forward and Mildred Gough have resigned from the Montreal staff, the former to do other work and the latter to be married. Dorothy McPherson has resigned from the Pictou staff to be married. Lenore Wellar and Jessie Lower have resigned from the Toronto staff. Jessie Tillett has resigned from the Sarnia staff to do industrial nursing.

M.L.I.C. Nursing Service

Louise Ahier (Notre Dame Hospital, Montreal) and Jeanne d'Arc Hamel (St. Sacrement Hospital, Quebec City) have been appointed to the Metropolitan nursing staff in Montreal.

Marie Anne Chess (Hotel Dieu de St. Joseph, Montreal, and University of Montreal public health nursing course), form-

erly in charge of the Metropolitan nursing service in Thetford Mines, P. Q., and Gilberte Violette (St. Sacrement Hospital, Quebec City, and University of Montreal public health nursing course), formerly in charge of the Metropolitan nursing service in Joliette, P. Q., have resigned from the Company's service.



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FEBRUARY, 1945

Nursing Sisters' Association of Canada

As the executive for 1945-46 was not appointed until the middle of November, requests for newsletters did not go out to the various units this year. Therefore the news is not complete but we hope for additional news later. Be sure to watch for it in *The Canadian Nurse*.

At the annual dinner of the Toronto Unit in November, five hundred dollars was voted to the "National" Nursing Sisters' Association for purposes of nursing rehabilitation. This fund represents our first post-war effort and it will be the nucleus to which we are confident all units will contribute for the difficult days ahead.

From Halifax came Christmas greetings to all sister units. Many Halifax members are busily engaged in aiding the war effort. Their duties include canteen, I.O.D.E., Red Cross, port nursing, sales of poppies, distribution of ration books, community drives. This eastern Canadian port has been a busy spot during the years of the war. The annual dinner and meeting was held November 11 at the attractive home of Miss Laura Hutley, R.R.C. and twenty-seven members had a jolly get-together. Mrs. E. R. Hughes (Gilham) of Kingston, Ont. was a welcome guest. Halifax is proud to have two members of the unit serving again in uniform-Matron M. B. MacNeil, A.R.R.C. of Halifax Military Hospital, and Nursing Sister Marguerite MacLean, A.R.R.C., posted to transport duty across Canada. The sympathy of the club goes out to Nursing Sister Mac-Lean in the loss of her brother in January and to Mrs. E. K. Gillis in the loss of her only son in October, 1944. Officers for 1944-45 include: past president, Marion Haliburton; president Mrs. W. S. Beattie (Janet Macdonald); vice-president, Josie Cameron; secretary, Edna C. Duthie; treasurer, Lillian Fitzgerald; sick visitor, Jane Hutley.

The Ottawa Unit held their annual meeting and Armistice dinner at the Chelsea Club on November 12. Brigadier C. G. Hepburn, M.C., Principal Protestant Chaplain, was guest speaker. He spoke on "Remembrance" and the spirit of comradeship which binds all those who have been associated in the great experiences of war. Miss Blanche Anderson moved a vote of thanks. Col. Elizabeth Smellie, C.B.E., R.R.C., gave a short report on the national convention held in Winnipeg last

June. Officers for 1944-45 include: president, Mrs. G. Spalding, R.R.C.; vice-president, Mrs. H. A. Caghill; secretary, Edith Bagnall; treasurer, Annie McNicol, R.R.C.; social convener, Mrs. H. J. Stitt.

The Vancouver Unit sent greetings to all nursing sisters in Canada and abroad. At the general meeting in September, Miss E. Gray gave a wonderful report of the national convention in Winnipeg. Sixteen Christmas parcels for husbands and sons of members were sent to various theatres of war. On Remembrance Day an afternoon tea was given at Hycroft to honour the veteran patients. There were several special guests and the husbands of our members. The veterans look forward to this tea as one of the high spots of the year, being entertained by their "sisters". The following Sunday the Overseas Nursing Sisters attended with the Amputation Association the Remembrance Day services in Canadian Memorial Church.

The Local Council of Women, with which we are affiliated, have arranged a short series of radio talks. On December 22, the nursing sisters took charge. Our unit plans to organize group insurance this year. Ninety-nine per cent of our members are working at Red Cross Branches, general duty in hospitals, in the men's service club or in industrial plants, besides retaining their interest and work in the Club. We still retain a box of comforts for the old and new army at Shaughnessy Hospital. This includes socks, sweaters and toilet articles. Chocolates were sent to Miss E. Martin, Edinburgh, for distribution to soldiers and sailors. At a drawing for the British Nurses Relief Fund we realized over \$400. A delightful garden party was held at the home of Mrs. Fitz-James and many old acquaintances renewed. Dressings are made at the Red Cross work rooms every Tuesday. Dressing dolls for our booth at the Trafalgar Day fair was of tremendous interest to the club members, and in this way we have kept in touch with nursing sisters all over B. C. This year we excelled ourselves and sent a cheque for \$360 to London, England, for the mine sweepers; we do this under the charter of the Ladies Guild, British Sailors Society. The executive for the coming year include: president E. McLane; vice-president, M. Motherwell; secretary, Mrs. Danby Smith; treasurer, E. V. Camcron; executive members, Mrs. McNutt, B.

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All units reported attending the Vesper Service in memory of Florence Nightingale and the special services on Armistice Day. In most cases a wreath is placed at the cenotaph. In Ottawa a wreath was also placed by the national executive of the Association.

The officers composing the national executive for 1944-46 are as follows: president, Maude Wilkinson; first vice-president, Isabelle McEwen; second vice-president, Mrs. Grace Gray Wilson; third vice-president, Mrs. C. A. Young; secretary-treasurer, Mrs. Helen Duff Forgan, 55 Highland Cres., York Mills, R.R.2, Toronto.

NEWS NOTES

ALBERTA

PONOKA:

A short business meeting of Ponoka District, No. 2, A.A.R.N., was held recently when the following officers were elected: president, Helen Furnell; vice-president Mrs. Ragnhild Olsen; secretary-treasurer,

Margarethe Lefsrund; representative to The Canadian Nurse, Mildred Nelson.

Nessa Leckie, formerly night supervisor at the Provincial Mental Hospital, has been awarded a C.N.A. bursary for post-graduate study, and is taking the course in teaching and supervision at the McGill School for Graduate Nurses. Mrs. R. Olsen (Bohmer) and P. Jamieson, 1944 graduates of Provincial Mental Hospital, have returned to



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the staff as supervisors. Ruth Parfett, formerly secretary-treasurer of Ponoka District, has recently been married. Helen Furnell and Kathleen Metheral returned to the Provincial Mental Hospital staff following the conclusion of the summer school courses in public health and teaching and supervision. Later Miss Metheral proceeded to the Calgary General Hospital as assistant instructor of nurses. Mrs. Lillian Stephenson (Mackie) has returned to the Provincial Mental Hospital staff as night supervisor.

A course in psychiatric nursing is well underway for a small group of graduate nurses.

EDMONTON:

At a recent regular monthly meeting of the Royal Alexandra Hospital Alumnae Association there were sixty-four members present, with the president, Miss Violet Chapman, in the chair. A sum was donated to the Red Cross for prisoners-of-war parcels. A nominating committee was appointed to select officers for the ensuing year. A letter was read from members in Vancouver who have met to discuss the possibility of forming a branch of the Alumnae in that city. There were thirty members present and the honour of cutting a huge cake was given to Mrs. Stella Dawson, of the Class of 1912. News letters have been sent to all members serving in the Armed Forces as well as to members in good standing.

The Rev. Canon A. M. Trendell, rector of All Saints Cathedral, gave us a most informative and interesting report on "Juvenile Delinquency". Canon Trendell is vitally interested in the problems of youth and as judge of the juvenile court speaks with authority on conditions as they exist today.

BRITISH COLUMBIA

VANCOUVER:

At a recent meeting of the Vancouver Chapter R.N.A.B.C., the guest speaker was Dr. Donald E. Starr. His lecture on "Pinning and Nailing" in orthopedic surgery pointed out the modern trends in that field. Dr. Starr illustrated his lecture by films and pictures. The V Bundle Committee, under the convenership of L. Drysdale, had a display of the children's toys which had been made by various groups. These toys are being sent to England for the British children. E. Brenner, M. Harwood, and C. Hess have recently joined UNRRA.

St. Paul's Hospital:

An open meeting of St. Paul's School of Nursing Alumnae Association for all graduate nurses of Vancouver was recently held. Dr. Elda Lindenfeld, eminent psychiatrist, was the guest speaker and her topic was "Insanity — its Prevention and Cure".

WEST VANCOUVER CHAPTER:

The offer of the West Vancouver Red Cross of the use of their premises for chapter meetings is gratefully accepted. A parcel has been sent to Miss Riddell, a former member, who is now overseas. M. I. Ewart was appointed as representative to the committee investigating the possibility of building a convalescent home for nurses on property at Caulfields.

NORTH VANCOUVER CHAPTER:

Miss Johnston has accepted the appointment to act on a committee for post-war planning for epidemics. Mrs. McDonald was appointed to act on the committee to investigate the project for a nurses convalescent home on Caulfields estate.

SMITHERS CHAPTER:

The Smithers Chapter is to be congratulated on their "aim for 1945" — to found and operate a well-baby clinic. At a recent meeting an interesting discussion on penicillin was held.

NOVA SCOTIA

HALIFAX:

Annie B. Brown (Children's Hospital, 1926) has joined the American Air Force Nursing Service and has been stationed at different posts throughout the United States and will proceed overseas in the near future.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Irene Weirs, Department of Public Health, City Hall. Fort William.

DISTRICT 1

Снатнам:

The Kent County industrial nurses invited the personnel managers of their firms to a recent meeting when Philip Alexander spoke



To keep hands smooth—Hand Cream

Scrubbing up leaves hands and arms red and sore — Cutex Hand Cream whitens, soothes and smooths them! Not sticky. Big full-ounce jar for only 39¢!





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Miss F. Munroe, R. N., Superintendent of Nurses, Royal Victoria Hospital, Montreal, P. Q.

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School for Graduate Nurses McGill University, Montreal 2 on "Oral Vaccines and Vitamins" and special films on venereal disease were shown. Program arrangements were in charge of Mrs. C. I. Salmon and L. Smythe. The December meeting took the form of a dinner with Mrs. Longuay of the Chrysler Corporation, Windsor, speaking on "The Problems for the Young Nurse in Industry". The Kent County Industrial Nurses organization is affiliated with the Public Health Section, R.N.A.O.

DISTRICTS 2 AND 3

KITCHENER:

An enthusiastic meeting of nurses from all parts of Districts 2 and 3, R.N.A.O., was held recently at Freeport Sanatorium. The day was ideal and suitable for travelling to this spot where we were warmly received by the lady superintendent, Miss Alice Bingeman. One hundred and fifty nurses and visitors were registered. Reports from section representatives showed more general interest in the profession throughout the District. Dr. S. J. Hawkins gave an informative address on "Tuberculosis and its Treatment". Miss Margaret Dulmage spoke on The Canadian Nurse and gave us some information on the work being done at present by the Red Cross Home Nursing Division. It was decided to purchase a Victory Bond. Following a turkey dinner served by the Sanatorium staff, we were entertained by Mr. William Cowls, of Kitchener, who told us, in his own way, what his plans would be fore post-war problems of the nursing profession. The election of officers later took place. The Spring meeting will be held in Brantford.

The annual meeting of the Kitchener and Waterloo Chapter was held in Waterloo, in the form of a dinner, with Miss Florence Weicker presiding. Forty-six members were present. Miss C. Attwood, of Stratford, who is membership convener of the District association, was present and asked the support of all members in her work. Dr. Olive Matthews, of Kitchener, gave a timely address on civic matters entitled "Is Your House in Order?" The election of officers was carried out, the new chairman being Miss Marie Felpush, Kitchener. Regular meetings are held in the City Hall, Kitchener, on the fourth Tuesday of each month.

Miss F. Weicker, of the Merchants Rubber Company, entertained the Kitchener and Waterloo industrial nurses at the plant at a recent regular meeting. Mr. W. Koehler, industrial relations manager, escorted the group through the factory after having given an interesting demonstration on the building of a rubber shoe. Several new members were welcomed to this meeting, including personnel workers employed by industries in the city. The following new officers were elected: chairman, F. Kudoba, Dominion Electrohome; secretary-treasurer, Nellie Scott, Dominion Tire Co.

Miss Weicker is now attending Waterloo College and E. Schuman has taken her place at the Merchants Rubber Co. M. Welsh has joined the R.C.A.F. Nursing Service.

DISTRICT 5

TORONTO:

The Ontario Hospital Association annual meeting in Toronto provides a broad interest for the members of District 5, R.N.A.O., as well as for all other nurses who can find it possible to attend. The Nurse Administrative Section this year was of particular interest and was under the chairmanship of Miss Elsie Jones, superintendent of nur-ses, Wellesley Hospital, Toronto. Miss Isa-bel Stewart, professor of nurse education, Teachers College, Columbia University, New York, made "Nurse Administration" a very vital interest to all nurses. The well-attended morning session was followed by a luncheon, addressed by Miss Marion Lindeburgh, past president of the C.N.A.

Increased interest of nurses is apparent in this section of the Association, whose board of directors includes for 1945 four members of the R.N.A.O.: Mrs. Muriel Cariss (McKee), Brantford, past president; Priscilla Campbell, Chatham, third vice-president; and Pearl Morrison, Toronto. Louise Acton, of Kingston, is also a member

as nurse representative.

Miss Isabelle McEwen, director of nursing, Red Cross Outpost Hospitals of Ontario, has been appointed a member of the committee to assist Dr. R. P. Vivian, Minister of Health for Ontario, to develop a "comprehensive over-all plan for hospitalization" for Ontario. Acute necessity is present for this project due to shortage of needed hospital beds.

Miss Jean Masten, superintendent of nur-ses, Hospital for Sick Children, Toronto, as president of the R.N.A.O., has been appointed the nursing representative on the Municipal Health Service Board authorized under the recently passed Municipal Health Services Act in Ontario. Members of the Board represent both those receiving ser-

vices and those providing them,

Toronto General Hospital:

Miss Edna Moore recently addressed the

T.G.H. staff meeting on "Nursing — To-day and Tomorrow". A reception followed. At a recent meeting of the Alumnae Asso-ciation Miss Margaret Aitken, of the Toronto Evening Telegram staff, gave a most interesting address on "A Newspaper Woman at Three War Conferences" from her own personal experience. At the reception which followed Lt.-Col. Agnes Neill, Matron-in-Chief, R.C.A.M.C. Overseas, who is home on leave from England, brought greetings to her Alumnae.

Toronto Western Hospital:

At a recent general staff meeting, Dr. A.

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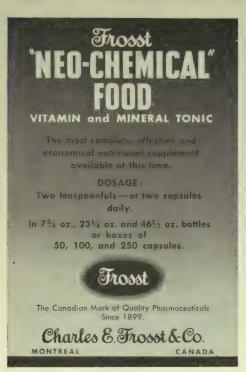
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The Director

NURSE PLACEMENT SERVICE

29 Wellington Row Saint John, N. B.





W. White, recently returned from the Mediterranean theatre of war, presented an illustrated lecture on "Fractures and their Treatment". The importance of exercise in the restoration of function to an involved joint is not fully realized, and few hospitals are equipped to give adequate treatment.

The Alumnae Association recently held a very successful tea at the Edith Cavell Residence. At a recent meeting Dr. A. I. Willinsky showed his latest technicolor film entitled "Mexicana". Scenes of life in Mexicowere portrayed in a very realistic and colour-

ful way.

Christmas parcels were sent to the forty-two graduates of the School now serving overseas with the R.C.A.M.C. Two scholar-ships have been awarded by the Association for one year's post-graduate study at a university, the recipients being Muriel Scrace for public health nursing, and Peggy Wood, clinical supervision in surgery.

Grant Macdonald Training School:

It has been the annual custom for the Grant Macdonald Training School Alumnae Association to serve afternoon tea to those attending the Christmas sale of work done by the patients of the occupational therapy department of the Queen Elizabeth Hospital on Dunn Avenue. This year the event was of necessity curtailed but a very satisfactory amount was realized. A raffle of a lovely pair of wool blankets made philanthropic activities secure for some time to come.

This Alumnae Association, of a School which has been discontinued, is called upon to take a normal part in nursing activities with decreasing numbers, instead of increasing. It is very gratifying to know that one can continue to take part under such condi-

tions.

DISTRICT 7

A meeting of District 7, R.N.A.O. was recently held at the Ontario Hospital, Rockwood, with fifty nurses present. Reports were read from the different chapters and sections. Dr. John Wylie, Professor of Preventive Medicine at Queen's University, gave an instructive and interesting illustrated talk on his public health experiences in Guatemala. Dr. Wylie was one of a party of ten doctors who went to Gautemala this past summer to study tropical disease, and his talk served to stress the widespread interest in public health today.

The attention of the meeting was directed to the new Community Health Council, Kingston, which is promoting a community recreation hall for the young people of Kingston. The support of the members was requested in the coming city election with respect to the need for the proposed community hall, and Miss Connelly, public health nurse, and Miss L. Gill of the Isolation Hospital, were appointed to sit on the Community

Health Council. Later, refreshments were served by Miss Smith, superintendent of nurses, and her staff.

The Kingston Chapter has held one meet-

ing with an attendance of sixty members, including several Nursing Sisters from No. 3 Military Hospital. The topic for discussion was occupational therapy, stressing the value it has in pediatrics, tuberculosis, orthopedics, Workmen's Compensation Board Clinic, and military and mental hospital fields.

The Brockville Chapter has been holding regular monthly meetings since October. Topics such as "Administration of Peniciland "Oxygen Therapy" have been dis-

cussed.

Brockville General Hospital:

The Alumnae Association of the Brockville General Hospital recently held a dance with the orchestra from the officers training centre at Brockville providing the music. Part of the proceeds were used for Christmas boxes which were sent to nurses serving overseas. During the last Victory Loan drive the Association invested in a Bond. Two prizes were given at the graduation this year and, in co-operation with the Board of Governors, the graduating class was entertained. New furniture has been purchased for the Alumnae Room in the hospital as well as three service tables for the Brockville International Blood Donor Clinic.

The following officers have been elected to serve during the coming year: honourary presidents, Alice Shannette, Edith Moffatt; president, Mrs. Mae White; first vice-president, Mrs. Wm. Cooke; second vice-president, Lucy Merkley; secretary, Mrs. Howard Bishop; corresponding secretary, Maude Arnold; treasurer, Mrs. H. Vandusen; con-veners: gift, Violet Kendrick; social, Mrs. H. Green; property, Mrs. M. Derry, J. McLaughlin, M. Gardiner; annual fees, Vera Preston; representative to The Canadian

Nurse, Helen Corbett.

DISTRICT 8

OTTAWA:

A well-attended refresher course, entitled "The Nurse's Responsibility in the Care of the Obstetrical Patient" was conducted by District 8, R.N.A.O., on December 11, 12, and 13, and held at the Civic and General Hospitals. On the first day Dr. Couture spoke at both sessions on Prenatal Care, and the Nursing Care was conducted at the after-noon session by Edith Stevenson, and at the evening session by Kate McIlraith, V.O.N., Ottawa.

The topic for December 12 was Labour and Dr. John Puddicombe was the speaker at the General Hospital, followed by Viola Downie who spoke on Nursing Care. At the Civic Hospital Dr. R. E. D. Cargill was the speaker and was ably assisted by Mary





TUBERCULOSIS NURSING

By Grace M. Longhurst. "The publication of a manual on nursing technic in tuberculosis hospitals has been long overdue. cuiosis nospitals has been long overdue... Miss Longhurst is to be highly complimented for having so successfully supplied this need. This book will prove of valuable help not only to nurses, but to all who are engaged in the care and treatment of tuberculous patients."— Robert E. Plunkett, M.D., General Superintendent of Tuberculosis Hospitals, New York State. \$4.40. \$4.40.

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An examination for the title and certificate of Registered Nurse of British Columbia will be held April 17, 18, and 19, 1945.

Names of Candidates for this examination must be in the office of the Registrar not later than March 17, 1945.

Full particulars may be obtained from:

ALICE L. WRIGHT, R.N., Registrar 1014 Vancouver Block, Vancouver, B. C.



Thompson, supervisor of the maternity floor

at the Civic Hospital.

On the last day Dr. W. J. Stevens discussed the Post-partum Period and H. O'Meara, University of Ottawa, discussed the Nursing Care. The evening session at the Civic Hospital was conducted by Dr. Puddicombe and the Nursing Care discussed by L. Barry, supervisor of the nursery at the Civic Hospital.

These lectures were most instructive and it was felt by all who attended that in the future their obstetrical patients would receive

more intelligent nursing care.

QUEBEC

Montreal General Hospital:

A recent visitor to the School was Bernice Kent, director of the pediatric department, Hahnemann Medical College and Hospital, Philadelphia. Miss Kent has recently been appointed a director with the United States

Cadet Nurse Corps.

Genevieve T. Piette (B.Sc. Columbia University), formerly with the Brooklyn Visiting Nursing Association and the Indian Service, and recently with the U.S.P.H.S. as public health staff nurse with the Balkan Mission, has now been appointed to UNRRA. Alison G. Reid has been appointed nurse-incharge of the dental clinic, Central Division, replacing Helen Miller who resigned. Madeleine I. Carr has joined the physical therapy staff, Central Division. Her work is associated with artificial fever therapy.

McGill School for Graduate Nurses:

The general meeting of the Alumnae Association was held recently when the students of the McGill School for Graduate Nurses were entertained at a Dessert Party pre-

vious to the meeting.

Recent visitors to the School were Louise Bartsch, Ethel Grindley, Helen Saunders, Grace Martin, Elizabeth Westren, Helen Leak, and Nursing Sisters Lois Bird, Alice

Palmquist, Jeannine Coupal.

OUEBEC CITY:

Jeffery Hale's Hospital:

Miss E. Frances Upton recently addressed a meeting of the Alumnae Association when she spoke on the highlights of the past biennial meeting, and discussed the organization of District 9 of the R.N.A.P.Q. A special meeting was called for the organization of the aforementioned district. Captain Hall recently addressed a meeting of the Association on "Adult Psychology". The Christmas formal dance was held at the end of December. All students who wrote the Fall R.N. examinations passed successfully. N/S MacIver and I. Greenwood (Henderson) recently returned from overseas.

SASKATCHEWAN

HUMBOLDT CHAPTER:

A course in first aid was given at Muenster under the direction of Mrs. O. A. Saddlemyer, Commandant, Emergency Nursing Reserve. It is worthy of note that Humboldt is the leading town in the Saskatoon District in the support given to blood donor clinics. Nurses assist at each of these.

Moose Jaw Chapter:

Nurses in this Chapter were responsible for eleven parcels sent to nursing sisters overseas. An interesting meeting when "Our Relationship to South America" was the subject of an address is also reported.

PRINCE ALBERT:

A meeting and Christmas party was held at the Prince Albert Sanatorium at which Mrs. Maggie Stephen was hostess. Forty-two nurses attended. Plans for the extension of the registry were discussed. Mrs. Verna McCrory presided.

REGINA:

A welcome illustration of the desire of nursing sisters to maintain contacts with their professional association is shown in an invitation received by the Regina Chapter to meet at the Nursing Sisters Mess, M.D. No. 12, when an interesting address was given on the "Inter-relationship between Social Work and Public Health Nursing" following which refreshments were served by the nursing sisters.

The Regina Chapter also reports the resignation of Mrs. D. Rowe, night registrar, and the appointment of Grace Moyer to this

position.

SASKATOON:

Advantage was taken at a recent meeting of an educational film, made available through the Audio-Visual Branch of the Department of Education, entitled "Windbreaks on the Prairies", depicting methods of soil conservation through the planting of trees. "White Battlefront", outlining a city's defence against disease, also proved of great interest.

The Catholic nurses of Saskatoon have formed a Catholic Nurses Association and

are organizing study groups.

Mrs. Elfrieda Schroeder has accepted the position of clinical instructor at St. Paul's Hospital. Lola Pearsall is taking the public health nursing course at the University of Toronto School of Nursing.



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Refresher Course in Nova Scotia

A refresher course in Public Health is to be held at two centres in Nova Scotia — in Halifax from February 19 to 24 and in Sydney from February 26 to March 3. This course is to be conducted by the Public.

Health Section of the Registered Nurses Association of Nova Scotia with Miss Mary Mathewson, Assistant Director of the McGill School for Graduate Nurses, as the speaker.

-F. M. BENNETT

Refresher Courses

During the past autumn, the School of Nursing, University of Toronto, included four refresher courses in its busy program. A four-day series on the teaching of home nursing was attended by eighty-seven prospective instructors. An intensive course in industrial nursing, covering one week, was

very stimulating to the 139 registrants. Twelve persons participated in an extension course in obstetrics which was spread over a period of two months. A lecture course in administration and supervision in nursing, with lectures given once a week from October to March, is being attended by fifty nurses.

Health Week in February

Many Canadian communities at the request of the Health League of Canada will observe a Health Week in February, the observance to coincide with the holding of National Social Hygiene Day, February 7. Health Week will open Sunday, February 4.

Purpose of the "Week" is to bring messages to Canadians on health as a basic factor in their lives — personal, communal and national. The League contends that only a nation of optimum health can discharge fully such great international responsibilities as

will have to be undertaken by the Dominion in the coming year.

Endorsation of the Health Week plan already has been received from departments of education and health in six provinces. Also, churches, schools, home and school associations and numerous women's and other organizations and service clubs have indicated a desire to co-operate in the extensive and ambitious program which is in course of preparation.

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An experienced Registered Nurse is required for the Hythe District Nursing Association. Interested applicants should write for particulars to:

R. F. Swanston, Secretary-Treasurer, Hythe District Nursing Association, Hythe, Alta.

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CANADIAN NURSE





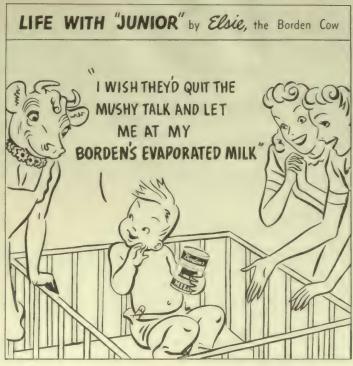


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After studying abroad, Osler was given the Chair in Medicine at McGill University. Later, he was appointed professor of clinical medicine in the University of Pennsylvania; Gulstonian lecturer at the Royal College of Physicians, London; professor of medicine at Johns Hopkins University; and regius professor of medicine at Oxford.

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MANUFACTURING PHARMACEUTISTS . 727-733 KING ST. WEST, TORONTO

MARCH, 1945 159

Reader's Guide

What can be done to prevent rheumatic fever and rheumatic heart disease? Since it is the leading cause of death among children of school age, it is important that we know everything possible about this disease - its nature, its signs and symtoms, its treatment, and how to protect susceptible children. This very vital topic is fully discussed for us by Dr. James H. Graham, chief interne at The Montreal General Hospital. Mildred M. Brogan, B.A., who outlines the essentials of nursing care, is a graduate of The Montreal General Hospital and before assuming her position of medical supervisor in her home school of nursing she took the course in teaching and supervision at McGill University. To round out the picture of rheumatic fever, Evelyn Pibus, a supervisor with the Victorian Order of Nurses in Montreal, points out the possible preventive program which may be developed in the community. Miss Pibus is a graduate in public health nursing from the McGill School for Graduate Nurses.

Lindeburgh has long been recognized as one of our most forwardlooking leaders in nursing education. Her analysis of the need for the fully qualified specialist in the clinical field, what constitutes adequate post-graduate training, and how the program should be developed jointly by the hospital and the university, contains much food for thought and discussion. Miss Lindeburgh, immediate past president of the Canadian Nurses Association, is director of the School for Graduate Nurses. McGill University. It is largely through her interest and initiative that the final arrangements have been completed for the new post-graduate course in psychiatric nursing between McGill University and the Allan Memorial Institute of the Royal Victoria Hospital in Montreal. For those who are interested in becoming clinical supervisors in this specialized field, this new course presents a splendid opportunity.

Grace M. Fairley has given us a clear picture of the reasons for the founding of the International Council of Nurses and the broad purposes it serves in coordinating the activities of nurses all over the world. Miss Fairley was elected third vice-president of the I.C.N. at the last meeting of the Congress in 1937. At the present time, she is president of the Registered Nurses Association of British Columbia.

Georgine Badeaux is a licentiate in social, economic and political science of the University of Montreal. At present she is tuberculosis nurse in Ville St. Laurent, Quebec. This paper was presented before the Society of Phthisiology in Montreal.

Dr. Harold B. Cushing is emeritus professor of pediatrics at McGill University. From the lofty height of his wide experience in pediatrics he indicates the reasons why more and more attention is being devoted to this specialty, not only by physicians but also by nurses.

This month marks the inauguration of still another new feature in the Journal. So that every nurse may be kept informed of what is being planned and done both in preparation for the return of the nurses who have been serving with the armed forces, and for the many thousands of nurses who have remained to serve on the home front, the Postwar Planning Committee will have a special article in each issue of the Journal. Keep yourself abreast of what is happening by following this series carefully.

Nursing Sister A. Whittaker, formerly of Yukon Territory, and now of Toronto, appears on our cover photographed during a "mercy flight" in an R.C. A.F. patrol bomber in Newfoundland. The baby was being flown from an isolated outpost to the hospital at St. John's. This photo was taken in flight in the aircraft's "gun blister".



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(1) Am. J. Obst. & Gyn., 35:839, 1938. (2) West. J. Surg., Obst. & Gyn., 51:150, 1943. (3) Clin. Med. & Surg., 46:327, 1939. (4) Med. Rec., 155:316, 1942.

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Garrod, L. P., and Keynes, G. L. (1937). Brit. med. J. 2, 1233

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The CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-ONE

NUMBER THREE

MARCH 1945

Our Fortieth Anniversary

Forty years ago this month, the first issue of *The Canadian Nurse* was published in Toronto with Doctor Helen MacMurchy as part-time editor and Miss Christie as the first business manager. Although the *Journal* was owned by a commercial firm, the editorial policy was controlled by an editorial board made up of nurses. Their plans for this new venture are outlined in the first brief editorial which reads:

The Canadian Nurse will be devoted to the interests of the nursing profession in Canada. It is the hope of its founders that this magazine may aid in uniting and uplifting the profession and in keeping alive that esprit de corps and desire to grow better and wiser in work and life which should always remain to us a daily ideal.

For the protection of the public and for the improvement of the profession *The Cana*dian *Nurse* will advocate legislation to enable properly qualified nurses to be registered by law. The policy of the magazine will be directed by the committee on publication and the business department will be conducted on business principles. The editors will be glad to receive manuscripts, and those accepted will be paid for on publication.

Names long familiar to nurses in Canada appear in the first issue. Miss Mary Agnes Snively contributed the leading article and her photograph forms the frontispiece. Isabel Hampton-Robb wrote about the problems of "The Nurse and the Public" in which she stated, in part:

As a class their (the nurses) position, and the good they do in the hospital is now unquestioned . . . But outside the hospital the trained nurse is still regarded as a not altogether unmixed blessing, and the public will need several more years of education . . . before they can be brought to thoroughly appreciate her position or the relative value of the services of the trained nurse, and those of the untrained attendant and the well-meaning, enthusiastic but untrained amateur

Esol Of Mura

. . . Nor would it be reasonable for us to look upon legal registration or other legislative enactments as a panacea for the present unsatisfactory condition of affairs, for always, as now, it will largely rest with ourselves what status we and our work are to hold in the eyes of the public at large.

A far-seeing woman, indeed!

In the beginning the Journal was published in quarterly issues. In presenting her report as business manager, Miss Christie said:

Owing to its undoubted success, the enthusiasm it has aroused and its growing popularity, we have great hopes of having it made in the near future a Dominion *Journal*, and issued monthly.

In 1907 The Canadian Nurse ceased to be a quarterly and ever since has appeared as a monthly issue. In 1911, Miss Belle Crosby succeeded Dr. Mac-Murchy as editor and held this position for five years. In 1916, the Journal was purchased by the Canadian National Association of Trained Nurses and became its official organ. Miss Helen Randal became the part-time editor and the publication of the Journal was transferred to Vancouver. In 1924, Miss Jean S. Wilson was appointed executive sec-

retary of the Canadian Nurses Association with headquarters in Winnipeg. With her secretarial duties, she combined the function of editor of the *Journal* until 1933 when Miss Ethel Johns was appointed as full-time editor and business manager and served in that capacity until 1944. The quarters were moved from Winnipeg to Montreal in 1932.

In the forty years, the Journal has grown both in size and circulation, perhaps beyond the dreams of its founders. The first issue contained twenty pages of editorial matter and twelve pages of advertising. An indication of the continued expansion may be seen in the 988 pages of volume 40; in the increased interest demonstrated by the sections in their respective pages; in the trend to use, more and more, the topics discussed in the Journal for reference reading; and in the increasing circulation. Let us hope that when the golden anniversary of the Journal is celebrated, The Canadian Nurse may truly be said to be not only the official organ of the National Association but an integral part of every nurse's equipment for her job.

---M.E.K.

Previews

Much has been written in the public press regarding the introduction of Children's Allowances, which will be instituted by the Federal Government this year. To clarify our thinking and increase our understanding of this notable development, we have asked Dr. George F. Davidson, Deputy Minister of Welfare, to interpret the proposed plan for us.

The problems of infant feeding, all

the involved details of determining which form of artificial feeding would prove most satisfactory for a particularly refractory case, the relative virtues of protein milk versus lactic acid milk, dextrimaltose versus karo syrup — Dr. Alton Goldbloom has included them all in his account of the various developments in infant feeding during the past twenty-five years. Even the grim humour of the role of the bean curds is portrayed in the April issue.

Rheumatic Fever

JAMES H. GRAHAM, M.D., C.M.

The organized medical attack that has been exerted against major public health problems in the last few years has appropriately featured as one of its major concerns the widespread scourge of rheumatic fever. Striking largely at the younger age groups, this disease kills more children from five to fourteen years of age than any other disease in the early and mid decades of life.

Rheumatic fever is an acute infectious disease affecting the fibrous tissue of the body and manifesting itself most commonly and most obviously in the joints and the heart. Unfortunately, when we discuss the cause of the disease we are still on rather uncertain territory, for a specific etiologic agent is not definitely known. Certain predisposing factors may be mentioned. The young age groups are more susceptible. It is a disease more common in the lower economic groups; some recent work suggests this may be associated at least in part with dietary insufficiencies. Wilson has recently emphasized an hereditary susceptibility to the disease. Geographically the disease is commoner in the cold, damp climate of the north temperate zone than in the subtropics or tropics. Coburn has pointed out that hemolytic streptococcal infections have a similar geographic distribution, and has actively pursued the question of the possible role of the hemolytic streptococcus as the precipitating agent in the etiology of rheumatic fever. His investigations have lead him to postulate that the rheumatic reaction is the result of a sensitization of the body to the hemolytic streptococcus. It has been recognized for many years that an acute pharyngitis, usually streptococcal, precedes a very large proportion of cases of acute rheumatic fever, to be followed in a variable period, usually ten to fourteen days, by the florid signs of the rheumatic affection. Coburn believes this to be explainable on the basis of the antigenic activity of the streptococcus stimulating the formation of antibodies, and the precipitation of the latter two factors setting off the rheumatic reaction in the tissues. Based on this theory, Coburn has elaborated a scheme of treatment and prophylaxis which will be discussed. Other theories as to the causative agent are largely variations on the streptococcal theory, some suggesting an associated factor such as a dietary deficiency, or a virus working in combination with the streptococcus.

The pathology of the acute stage of the disease is characterized by an inflammatory reaction which may occur in and about the joints; in the lining, the muscle, the covering tissue, and the valves of the heart; in subcutaneous tissue, pleura, peritoneum, arteries, brain or its covering layers, and in other parts of the body. The cellular reaction in rheumatic inflammation is characteristic and is most typically shown in the so-called "Aschoff body".

Of all these possible sites of rheumatic activity, by far the most important is the heart. As was mentioned above, all parts of the heart are involved. With recovery, the inflammatory reaction is replaced at least partly by scar formation. This can affect the pericardium producing adhesions; it causes minute scarring through the myocardium. The scarring, contraction, and progressive degenerative changes in the heart valves are responsible for the deformity of the valves spoken of clinically as "insufficiency" and "stenosis". By insufficiency, we mean that the valve, scarred and contracted, no longer can act as an effective barrier to blood flow during the particular phase of the heart cycle when

MARCH, 1945

it should be closed. This permits an escape of blood through the valve, and produces a heart murmur. By stenosis we mean that the valvular disease has progressed to the point that there is actually obstruction to the outflow of blood through that valve during the stage of the heart cycle when the valve should be open. This likewise produces a heart murmur. Most common valve affected is the mitral valve; next in line is the aortic, rarely the tricuspid and very rarely the pulmonary. More than one valve may be involved; one sometimes sees cases with three valves involved. Recurrences of the rheumatic fever may cause further involvement and scarring of the valves. Not all cases, of course, suffer such advanced changes. The high incidence of rheumatic fever was commented on earlier; it is not hard to understand that it is the leading cause of valvular heart disease.

The symptomatology of acute rheumatic fever is well known to every nurse who has trained on a medical ward. Onset with some type of acute respiratory infection is common and characteristic. Nose bleeds may be a feature. There is fever, usually moderate. The pulse is rapid, and in more severe cases sometimes irregular. It is important to accurately record the pulse rate, as persistent rapidity when the symptoms have regressed may signify persistent rheumatic involvement of the heart.

The respirations are increased, sometimes markedly so, in children. The typical case has several of the larger joints inflamed, the arthritis tending to regress in one joint, flare up in another. The patient may resent even slight jarring of the bed, so severe is the pain in his swollen, reddened joints. There is a tendency to profuse sweating, and some describe a characteristic odour to these patients, sometimes referred to as "musty", which, as is true of many of these more minute clinical observations, is better known to the veteran nurse than to the physician.

Palpation of the skin may reveal small nodules in the subcutaneous tissue, more common over extensor surfaces and bony prominences, but often better seen than felt. Several types of skin rashes may develop. The white blood cell count is increased, and the red blood cell sedimentation rate is rapid. This latter laboratory test is perhaps the most valuable and sensitive index of rheumatic activity, and should be repeated at intervals of not more than one week The electrocardiogram shows changes in the acute stage, and heart murmurs may develop. If the pleura is involved in the rheumatic inflammation, the patient will complain of pain in the chest.

Any discussion of the symptomatology of rheumatic infection must include a reference to chorea. This manifestation characterized by continuous jerky, involuntary movements, may be the only overt evidence of a rheumatic attack. There is now little doubt that it is merely a cerebral expression of rheumatic fever. One occasionally sees cases of valvular heart disease of a typical rheumatic type in young persons who give no history of joint pains but who do admit to one or several bouts of chorea.

The length of any one attack of the disease is variable and will be modified by treatment. Swift has described three types of cases, one lasting a ten-to-four-teen-day period, and showing the varied symptoms and signs as described above without further flare-ups. This he calls the "monocyclic type". Where there is more than one flare-up, he calls the course "polycyclic". The third type is labelled "continuous" and in it the patient shows at all times one or more signs of the disease.

In general one may say that in children the heart bears the brunt of the attack, while in adolescence and onward the disease is more characterized by arthritis with less damage to the heart. Not all cases are obvious and typical in their signs. "Subclinical" states of ill-health ascribable to rheumatic infection

are known, a type of case that has been called "the unwell child". It has often been said that "growing pains" may be mild rheumatic joint pains.

The diagnosis of the disease is not difficult when the symptoms and signs are classical, but one must differentiate it from other forms of arthritis, and from osteomyelitis, cellulitis, and other diseases characterized by sore throat or acute upper respiratory infection. There are no specific laboratory tests that will make the diagnosis; it must be made on clinical judgment.

The mortality in the acute phase is described by Swift as 1 to 4 per cent. Wilson and Lubschez have recently reported on recurrence rates in acute rheumatic fever, and have shown that the chances of recurrence are greater in younger persons, and in the year following the attack. Many more lives are claimed later in life as the damaging results of the disease on the heart lead to heart failure, or to the development of infection on the diseased heart valves — the dreaded "bacterial endocarditis".

The treatment of acute rheumatic fever requires strict bed rest. Fluid intake must be good, as large amounts are lost through perspiration. Diet may be as tolerated, but if anorexia is marked in the febrile stage, a more easily tolerated febrile diet is recommended. Pains in the affected joints may be somewhat relieved by local heat, and other measures such as are described in the article on the nursing care of the disease by Miss Brogan in this issue.

The treatment of rheumatic fever has long featured the use of salicylate drugs. Sodium salicylate and acetyl salicylic acid (aspirin) are the two common types of salicylates used, and the relief of the distressing symptoms by the use of these drugs is dramatic. Of great interest is the recent work of Coburn using large doses of salicylates over considerable periods of time. He has found that doses adequate for relief of symp-

toms do not necessarily check the inflammatory process, that higher and more prolonged salicylate dosage is required to attain this, and presents data to demonstrate that to effectively check the rheumatic inflammation a blood plasma salicylate level of at least 350 micrograms is required. To rapidly obtain a high level he administers the drug intravenously over a six-day period, ten grams being given the first day, twenty the second day, and ten grams on the third to sixth days; each ten grams is administered in a litre of sterile physiological saline over a period of from four to six hours. From the seventh to the thirtieth day of the course, the drug is given orally, ten grams being given per twenty-four hours (1.6 grams sodium salicylate with 0.6 grams sodium bicarbonate, q 4 h.) The red blood cell sedimentation rate is carefully followed. If the rate is still elevated after the thirty days the therapy is continued; if it has been normal for two weeks, the therapy is discontinued and the patient observed during one week of bed rest. A flare-up is treated by a resumption of salicylate therapy, but if the patient remains well the salicylate is not resumed. During administration of the drug, plasma salicylate levels are done frequently to ensure that a sufficiently high level is being maintained.

Using this regime on thirty-eight patients, Coburn observed no resultant rheumatic heart disease, while twenty-one of sixty-three patients (33 per cent) treated with small doses of salicylates did show evidence of heart disease. These figures are indeed striking and a shining hope in the rheumatic fever problem.

For those so situated that intravenous therapy cannot be used, or where sterile sodium salicylate for intravenous use is not available, it should be remembered that ten grams of sodium salicylate daily for thirty days is the recommended minimum.

Commoner toxic symptoms of salicy-

lates are ringing in the ears, slight deafness, feeling of fullness in the head, nausea and vomiting. These are very often serious and disappear rapidly when the drug is reduced or temporarily discontinued. A more serious effect in some persons is a depression of the blood prothrombin and resultant hemorrhagic manifestations. Vitamin K should be administered to forestall this complication.

Other drugs sometimes used are the cinchophen drugs and amidopyrine. These drugs produce symptomatic relief similar to salicylates, but their potential dangerous toxic effects are now so well known that one cannot recommend their use. Sulphonamide drugs are not valuable in the acute attack, and it has recently been shown that penicillin is of no value. Digitalis is not indicated in the acute phase. A tendency to anemia may be combatted with iron and adequate diet.

While there is indeed much of new interest in the above discussion of therapy there are equally interesting new developments in the field of prevention. If one accepts Coburn's proposition of the development of rheumatic fever as described, it will be seen that prevention might be attained by (a) preventing antigen-antibody precipitation if infection with hemolytic streptococci occurs, or, better, (b) preventing the hemolytic streptococcal infection. Several workers have shown that the first of these may in a large proportion of cases be attained by giving daily doses of salicylates for about four weeks if a hemolytic streptococcus infection develops. The second ideal, that is prevention of hemolytic streptococcal infections, can largely be attained by giving a daily dose of a sulphonamide drug. This has been recognized for some years but has been strikingly underlined in a recent paper by Caroline Thomas. In this report, Dr. Thomas reveals a startling reduction in respiratory disease, streptococcal infections, and rheumatic fever in a large group (250,000) of United States Army personnel who received one gram of sulphadiazine daily for four months. The incidence of toxic reaction was very small. In view of the number of favorable reports of this method of prophylaxis, it would seem wise to recommend that a daily dose of one gram of sulphadiazine be administered to rheumatic patients over that period of the year when respiratory infections are common, that is, from October to May. Some feel that this should be carried on for the full year. The patient should, of course, be frequently observed for possible toxic effects of the sulpha drug.

The question of whether tonsillectomy should be done as a prophylactic measure in rheumatic cases is still in dispute. Reports are conflicting but, in general, this measure is in less favour than formerly, and it is felt that the operation is warranted only in those cases where there are the customary accepted indications for tonsillectomy. Changes of residence to a geographic area free of hemolytic streptococcal infections is a scarcely practical mode of prophylaxis, for the vast majority at least. Wasson and Brown have claimed some preventive merit in hemolytic streptococcus immunization, but this has not gained general favour.

In summary it may be said that the sulphonamide method presents the most hopeful prophylactic regime at the moment, and it should be instituted before the patient is discharged from the physician's care after his acute attack.

This has been an attempt to discuss rheumatic fever from the physician's viewpoint which is but one aspect of the problem. The nursing and public health aspects are also discussed in this issue, in an effort to present a broad survey of the rheumatic fever problem.

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Nursing Care in Acute Rheumatic Fever

MILDRED M. BROGAN

Rheumatic fever is a disease which requires skilful and intelligent nursing care. As nurses, we must administer the prescribed drugs, generally some form of salicylates; and continually watch for their toxic signs and symptoms, such as, tinnitus, deafness, nausea, vomiting and sometimes delirium.

The attending doctor should be notified immediately at the onset of these toxic manifestations and, although the drug may be continued, in all probability the dosage will be reduced. It is also the nurse who keeps a constant and accurate check on the patient's pulse. It is most important that we should count the pulse rate for a full minute in order that the doctor can be guided by our record, as the pulse is of cardinal significance in diagnosing and treating rheumatic fever.

The comfort of the patient is of foremost importance. The bed must be properly made, using flannelette sheets, and a flannelette gown should always be worn as this type of patient perspires profusely and flannelette is so much more absorbent. Rheumatic sweats necessitate frequent tepid sponges besides the daily bath, in order to ensure constant body cleanliness, so conducive to the patient's physical and mental comfort. While sponging the patient, the nurse has an excellent opportunity to remark any skin eruptions. Erythema nodosum and erythema multiforme are not uncommon.

Persons with rheumatic fever always complain of migrating joint pains. If these painful joints are gently rubbed with oil of wintergreen, then covered with non-absorbent cotton, and held in place by many-tailed bandages much pain is alleviated. This method of bandaging requires the least amount of handling of the painful joints, and thus safeguards the patient's comfort.

I cannot over-emphasize how skilfully and gently these patients must be handled during the acute stage as even the slightest jarring of the bed causes them excruciating pain. This disease gives the good nurse an ideal opportunity of applying her training and ingenuity in making her patient comfortable. The weight of the bed clothes can be

removed by using a cradle. We must always support the painful joints on pillows or by means of sand bags or splints. The foot board is ever-helpful in preventing "drop foot" as these patients are in bed for a long period of time.

It must always be borne in mind that everything should be done for the patient in order to conserve his energy. It is the nurse's responsibility to organize her work in such a way that she gives her patient complete care at one time thus avoiding frequent disturbances. While in the acute stage the rheumatic fever patient should be fed. No particular diet is ordered, but we, as nurses, must prevent the patient developing nutritional anemia. Doubtless, if we were in bed suffering with joint pains, our appetites would lag. So, we must do everything we can to make our patient's meals nutritious, palatable, and attractive. Sufficient bulk and laxative food must be included in the diet in order to ensure regular elimination. It is very poor nursing care to subject these patients to enemata or purgatives q.2.d.

All the preceding suggestions are conducive to physical comfort, but we must constantly remember the patient's mental comfort also. Rest is a necessity in the care and treatment of rheumatic fever. In hospital, the nurses are responsible for making their patient's environment as restful as possible. Fresh air, sunshine, a quiet tidy ward, and a restricted number of visitors are all healthful rest measures.

Social service can alleviate many mental and financial worries which will really allow the patient to rest, as it is hard to relax if you are not sure how your loved ones are managing at home, or how you are going to pay your hospital bill.

The acute stage of rheumatic fever generally lasts approximately ten to fourteen days after which the patient must remain in bed a month or longer till his sedimentation rate returns to normal. During this latter period every patient should have the benefit of occupational therapy. An interesting book which the nurse can subtly recommend, a short lesson in making swabs and dressings, can make the day go so much more quickly and help to keep up the patient's morale because he will feel he is doing something useful.

When the sedimentation rate is normal and the pulse rate is satisfactory the doctor instructs the nurse to get the patient up. Here is an occasion when the nurse may do some health teaching. She instructs her patient to first sit on the side of his bed. If there are no ill effects, the next day she helps him to get up in a chair, always keeping a close check on his pulse rate and reporting this rate to the physician. The pulse rate should be counted for a full minute before exertion, immediately after exertion, and five minutes after exertion has ceased. After the patient has been up several times in a chair, unless contra-indicated, he is allowed to walk and resume exercise gradually. It is our responsibility to see to it that the patient realizes his capacity for resuming normal life again. We should always encourage these patients to lead as normal a life as possible without overtaxing their strength. We must not forget that every rheumatic patient is a potential cardiac and, as such, sometimes it is necessary for them to change their positions and their mode of living.

When the day comes and our patient is ready to leave hospital he should have acquired some very healthful habits which will help him in his everyday life. He should realize the importance of rest, proper diet, fresh air, sunshine and proper elimination. He is aware of his ability to increase his work gradually and if the nurse is really alert she will not allow this patient to go out into the community without recommending him to some public health agency which will take up the good work begun in the hospital and carry it through. This health supervision offered in the com-

munity adds tremendously to the patient's sense of security which is so important.

Whenever our hospital discharges a

patient who has had rheumatic fever, he is recommended to attend our cardiac clinic, where periodic check-ups and electrocardiograms may be done.

Public Health Aspects of Rheumatic Fever

EVELYN PIBUS

It is necessary to recognize rheumatic fever as a public health problem, if children and adults are to be saved from death and the crippling effects of rheumatic heart disease.

Dr. Paul, professor of preventive medecine, Yale University, in speaking of the prevalence of rheumatic fever in the United States says, "Rheumatic fever is a disease which in most parts of this country may be classed as our third most common (after tuberculosis and syphilis) chronic infection". Dr. Paul goes on to say that none of the methods at present available for compiling statistics in regard to morbidity and mortality are satisfactory or give a complete picture of this disease, but that the mortality from rheumatic heart disease may be utilized as one index of the importance of rheumatic fever.

In a table, relative mortality from various infectious diseases compiled for New York City in 1938, we see the following picture:

Disease	Number of	Rate per
	deaths	100,000
Whooping cough	105	1.40
Epidemic meningitis	53	0. 7
Measles	42	0.56
Diphtheria	26	0.35
Scarlet fever	17	0.23
Poliomyelitis	4	0.05
Total	247	3.29
Rheumatic heart di	isease 958	
Rheumatic fever	147	
Total	1,105	14.7
Tuberculosis — all	forms 3,833	50.3

A study of deaths from rheumatic heart disease made in the city of Philadelphia in 1936 revealed that the total mortality from this disease was about 25 to 30 per 100,000, and among infectious diseases this was exceeded as a cause of death only by tuberculosis, lobar pneumonia and syphilis.

This occurs in American cities but it is probable a similar rate would be found for any of our Canadian cities. There is a fairly general agreement that the disease is common and severe in temperate zones and that it occurs more frequently among urban than among rural populations.

Tuberculosis is the problem most familiar to the majority of public health workers, and there is considerable similarity in the nature of tuberculosis and rheumatic fever as public health problems. There is one great difference, that the specific cause of rheumatic fever has not yet been determined, so it is necessary that prevention follow along the rather general lines of the knowledge at present available. How then shall we approach this problem of preventing rheumatic fever and rheumatic disease? Perhaps it will be easier if I attempt to suggest methods of approach under definite headings.

Education and Co-operation:

Dr. Paul emphasized the need for more knowledge, especially among professional workers, of the nature of rheumatic fever and of the broad aspects of the management of the disease. He

stressed the need for the many services which are necessary beyond those of the physician and the heart clinic. The problems arising from the careful and prolonged care necessary for these patients cannot be solved by individuals working alone. The cardiac clinic can be the keystone of any local program but adequate care requires co-operation on the part of those coming in contact with the patient. This applies both to individuals and organizations in the community. Dr. Wheatley says "The tendency of the disease to recur demands that plans be developed to educate teachers, parents, social workers and others, in daily association with the child, to recognize the manifestations of rheumatic activity and the importance of periodic medical examination." Lay education is necessary if professional workers and organizations are to receive the support necessary to obtain facilities for the care of these patients.

Case Finding and Prevention:

Public health workers and organizations are very much alive to their responsibilities in case finding in tuberculosis. If we accept rheumatic fever as the public health problem it really is, then we must also accept responsibility for being on the alert to detect possible cases of rheumatic heart disease. Dr. Graham has discussed environment as one of the pre-disposing causes of rheumatic fever. The same living conditions we know to be pre-disposing factors of tuberculosis are shown to be fruitful soil also for rheumatic fever. He has also discussed the association of rheumatic fever with streptococcal infection and the fact that it may be seen as a family disease. Bearing these things in mind, then, let us see what other knowledge we may have to help us in case finding and prevention, and how we can apply this knowledge.

In studies made of this disease it has been stated that the active disease seems to find its greatest prevalence in childhood, with first attacks occurring most

frequently between the ages of five and fifteen years. Primary attacks predispose to recurrent attacks, therefore, the active disease is also common during adolescence and young adult life. Dr. Paul has stated that the peak appears to be between six and nine years but that, due to missed and unrecognized cases, it is often difficult to determine whether the child of twelve years who comes to hospital with the first clear-cut picture of rheumatic fever has had a previous "missed" attack. The term rheumatism means a variety of human ailments to the lay person's mind, and is usually associated with old people. Therefore, it is not strange that a busy mother pays little attention to the school child's occasional complaint of pains in legs or arms and considers these as "growing pains", something that will pass. Then there is the pale, listless child who does not eat well, has frequent colds and tires more easily than other members of the family. Do we too frequently in our busyness forget to enquire about the school child who is not in the home when we visit? Do we listen attentively when the mother tells us about a child who has "growing pains", or has developed a slight limp, or about the child who complains of fatigue and doesn't seem to be interested in school? Is it not our responsibility to enquire more carefully into this and perhaps consult with the school nurse in regard to the child's last physical examination and whether this child should again be seen by a doctor? Here, too, we have a responsibility in helping the mother to understand the nature and dangers of communicable disease, and to discuss and explain any known means of preventing these diseases. Do we pay particular attention to the health of the child between the age of nine and ten, the fatigue year, when the heart is relatively large in proportion to the rest of the body, or again between the age of fourteen and fifteen when there is usually the greatest growth in stature?

In considering the family as a unit through which rheumatic fever may spread, our approach to prevention and case finding in families of known cases might be similar to that used in families where there is tuberculosis. Improving and studying the information contained in our family health and social histories might also be a help in controlling this disease.

Provision for Care:

The problem of care in this disease can be divided into three stages: (1) Care of the acute stage; (2) care of the sub-acute stage, which is often prolonged; and (3) follow-up care.

Miss Brogan has dealt with the care of the acute stage. The care needed during the sub-acute stage has been described as "sanatorial type" care, and may be provided in an institution, a foster home, or the patient's own home. Institutional care, for a short time at least, is most desirable as during this time the patient learns how to rest, why he must rest, and he is helped to accept and adjust to this prolonged period in bed. Provision to have schooling continued is essential. Occupational therapy administered with the consent of the doctor is important in helping the patient make a satisfactory adjustment to his illness. If, as is so frequently the case, no institutional care, even for a short time, is available then the child must return to his own home. If the living conditions in this home are unsatisfactory, it is desirable to draw upon any available community resources to improve these conditions before the child's return. It is necessary to provide for adequate medical and nursing supervision at this time, and every effort should be made to improve living habits and nutrition.

Follow-up Care during the Inactive Stage:

It has been noted that rheumatic fever tends to recur, each succeeding attack usually causing more damage to the heart. It is, therefore, in these repeated attacks that the greatest danger lies. It is quite possible for a child to have one attack of rheumatic fever and make a complete recovery. Again we could draw our parallel to tuberculosis and say that the "cured" child should be as carefully followed and checked as the tuberculosis "cure".

Perhaps we can best demonstrate the need for careful follow-up and cooperation in planning for this care by considering the case of Peter, a bright ten-year-old who had his first recognized attack of acute rheumatic fever following pneumonia. This child was cared for at home by the Victorian Order nurse. The mother was intelligent, though rather sensitive about accepting advice about the care of her children. She appeared to be a little fearful that her ability to care for Peter was being questioned. This very natural reaction called for a thoughtful approach that would reassure her, and the wise use of teaching methods and knowledge. We sometimes forget that teaching is much more than "telling" and perhaps are too prone to plan for our families rather than with them. Peter's history showed that he had never been a vigorous child, and had always been a rather small and finicky eater. By the time he was able to sit up for a short time each day, the nurse had caught his interest in the daily rations of the men in the R.C.A.F. and had planned with the mother for his particular needs in regard to rest, nutrition and continued medical supervision. The nurse felt that at this point the mother could best carry on alone, so she decided to see the child early in the fall to help with plans for winter care. This visit was made and the nurse was encouraged to find that Peter had been taken to the doctor for an examination before returning to school. The mother welcomed the nurse and together they discussed such things as food, the warm underwear already bought, and the problem of keeping a real boy from getting wet and chilled. The need for medical supervision during and after any acute infection was explained and the reasons given for keeping Peter at home and in bed at the first sign of a cold. This, the mother said, was certainly going to be a problem as Peter would most surely rebel against being kept at home for a slight cold. The mother was concerned about his ability to take part in games at school. Here the nurse suggested that she consult with the school doctor and nurse about Peter's program. The school, through its medical and nursing supervision, is an important link in the chain of supervision.

Extension of Care beyond Childhood:

The high morbidity and mortality resulting from heart disease among the adult population indicates that medical supervision should be continued throughout adult life. Much chronic invalidism might be avoided and the life span of many people be extended if the preven-

tive value of adult health examination was more fully realized. The ultimate aim of any public health program in regard to rheumatic fever is its early diagnosis, improvement of living conditions, and the prevention of recurrent attacks in the hope that rheumatic heart disease may be retarded or prevented.

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What Constitutes Post-Graduate Clinical Courses?

MARION LINDEBURGH

For years, hospitals and schools of nursing have suffered greatly from the lack of qualified and experienced nurses to assume administrative, teaching, and supervisory responsibilities in special clinical fields. War-time demands have further depleted the supply, and this deficiency has brought about a serious problem. Administrators are fully aware of the need for effective clinical teaching and expert supervision in order that standards of nursing service and nursing education in all clinical services may be maintained. The urgent need, therefore, for post-graduate study and experience in the preparation of promising nurses for positions of responsibility in particular clinical services is fully realized. The nursing profession is now vitally concerned with standards relating to post-

graduate clinical education. Two excellent articles have appeared in the American Journal of Nursing, dealing with the need for and the requirements of these clinical courses. One appears in the December, 1943, issue entitled, "Postgraduate Nursing Programs" and the other under the title "Advanced Courses in Clinical Nursing" in the June, 1943, number. These articles have evolved from the work of a special committee, appointed by the National League of Nursing Education in 1943, to study post-graduate clinical courses. They deal with findings and include recommendations. One should not overlook an article written at a much earlier date by Miss Isabel M. Stewart of Teachers College, "Post-graduate Education - Old and New" and published in the April, 1933, number of the American Journal of Nursing. It contains sound proposals, whereby postgraduate clinical courses could be established on a sounder educational basis. The Canadian Nurses Association has made certain recommendations relative to the organization and administration of clinical courses on a graduate level. (See The Canadian Nurse, November, 1943, page 750.) These recommendations should be studied carefully and accepted as guiding principles.

When the war is over, more than two thousand nurses will be returning to Canada from overseas. It is hoped that many of them will take full advantage of the financial assistance provided by the Government to undertake whatever study or nursing experience they desire. Answers to the questionnaire sent to all nursing sisters indicate that many nurses upon demobilization plan to undertake specialization in nursing. Therefore, the establishment of the necessary clinical facilities to meet demands for post-graduate work in hospitals should receive immediate attention.

Existing Post-graduate Courses:

In considering standards for postgraduate nursing education in hospital departments, it is necessary that the purpose and calibre of the courses be clearly defined. Post-graduate courses now being offered in hospitals throughout Canada vary considerably in level and quality of experience secured. In many instances graduate nurses seek further experience because of some weakness or omission in their basic training, or they may wish to bring themselves up-to-date with new knowledge and technique, all for the purpose of becoming better equipped to nurse in that particular field. Courses offered to meet deficiencies and to supplement the basic training serve a very useful purpose, and they will con-

tinue to be in demand until all schools of nursing can provide a sounder background course for the general practice of nursing. An examination of these socalled post-graduate courses would indicate that in the majority of instances they are organized on a student rather than on a graduate level. They are planned on a partly economic and partly educational basis. In many instances, they provide the hospital with an additional nursing staff, and at the same time they afford graduate nurses the opportunity to brush up, or to make up the deficiency in their training. Many of these courses, even in special hospitals, are of this type, little distinction being made in the case of nurses enrolled for post-graduate work, and affiliating undergraduate students. Both groups frequently attend the same lectures and their nursing assignments on the wards are fairly comparable. The following statement regarding "Post-graduate Courses" is quoted from the report of the Committee on Nursing and Nursing Education in The Canadian Hospital, 1941:

The statements received by this committee from representatives in the nine provinces indicate that, with few exceptions, the courses offered in Canada at the present time are little more than additional experience, often undertaken under very definite pressure of hospital service, and as one means of providing for this. This arrangement is entirely unsatisfactory both to hospital administrators and to the so-called post-graduate student. Superintendents of nurses in a number of hospitals have made valiant efforts to share the additional experience which they have to offer with graduates from other schools; again others have not felt justified in even suggesting this type of post-graduate work. In many instances, the experience offered has been frankly suggested in lieu of something better and the nurse has benefitted by it. However, any course taken after graduation from a school of nursing without regard to purpose or standards is not post-graduate work.

THE ADVANCED TYPE OF POST-GRADUATE CLINICAL COURSE:

The advanced type of post-graduate experience should be organized strictly on an educational basis. While the practice program will be of some service benefit to the hospital, the post-graduate student should not be included in tite nursing staff. This point is emphasized because it is fundamental to post-graduate study. It will have a direct bearing upon the policy relating to tuition fees in order to offset the cost of the special instruction and supervision which must be provided. The course should be designed to prepare the graduate nurse as a specialist in her field and to enable her to undertake administrative, teaching, and supervisory responsibility. The basic course should be considered as a foundation upon which and beyond which the post-graduate or specialization course is organized. The head nurse and clinical supervisor need to be prepared well beyond the level of the general practitioner in nursing, in knowledge, in nursing techniques, and in methods relating to administration, teaching and supervision.

Some Important Considerations in Setting Standards for Post-graduate Courses in Clinical Fields:

Clinical courses which supplement the undergraduate course: Courses which are taken to supplement the basic training should be recognized as such. In many instances they should be improved in order to be of greater value, but they should not be recognized as the type of post-graduate course which is designed to prepare for specialization and leadership in a particular field of nursing.

The use of hospitals with and without schools of nursing: Hospitals offering post-graduate courses which are also conducting schools of nursing must make a clear distinction between the instruction and practice required for student nurses and the experience needed on a more advanced level to meet the needs

of the graduate nurses seeking postgraduate experience. Hospitals which are not conducting schools but which are accepting affiliating student nurses, must also discriminate between the educational needs of students and graduate nurses. Hospitals offering post-graduate courses should be on the "Approved" list. They should be well supported financially and should have well qualified medical and nursing personnel.

Special hospitals should be utilized whenever possible for post-graduate work — for instance, a children's hospital should offer better clinical resources and facilities for post-graduate experience than are available in a pediatric department within a general hospital.

Hospitals offering post-graduate courses should be adequately staffed. Firstly, in order that good nursing standards may be maintained; secondly, in order that the educational experience of post-graduate students will not be subordinated to the service needs of the hospital. It is also necessary that the hospital wards be well equipped.

The clinical services: Post-graduate courses can be established in all branches of hospital service; namely, medical, surgical, obstetrical, pediatric, eye, ear, nose, and throat, operating-room, psychiatry, communicable diseases, and so forth. There is also a need for technical courses in laboratory, x-ray, physiotherapy and in other fields by which the graduate nurse can become a qualified technician.

Co-ordination of hospital experience and university courses: While nursing departments in universities offer courses for the general preparation of administrators, teachers, and supervisors, there is a definite need for the organization of well-planned post-graduate courses in clinical departments in conjunction with special related courses in the university. Hospitals should be encouraged to analyze their facilities, and if clinical resources are adequate, an attempt should be made to organize these post-graduate courses on a sounder education-

al basis. Exceptionally good clinical facilities are needed for this advanced nursing experience, also a highly qualified medical and nursing teaching staff, which are more likely to be secured in teaching hospitals connected with universities.

The need for a specially prepared supervisor: It would seem necessary that a specially-prepared clinical supervisor be appointed to assume responsibility for the teaching and supervision of post-graduate students. She should direct their clinical experience in order that every opportunity may be utilized for their educational benefit. She should also assume specific teaching responsibilities related to the nursing specialty.

The eligibility of the applicant: Graduate nurses seeking post-graduate study should meet certain specified educational and professional requirements. The applicant should possess matriculation standing; she should be a graduate of an approved school of nursing, in which classroom and clinical experience meet the requirements as outlined in "A Proposed Curriculum for Schools of Nursing in Canada". The record of the applicant should show a satisfactory basic experience in the special field of nursing in which specialization is being sought. Every effort should be made to determine the interest and potentialities of the applicant, and probability of success in the particular clinical field.

Nurses seeking post-graduate experience should have at least one year's experience before commencing post-graduate work.

Tuition fees: General inquiry regarding fees indicates that in most instances post-graduate students receive a small remuneration. It is evident that many hospitals are sponsoring post-graduate courses on the basis that students will contribute materially to the nursing service, and for this remuneration is given. Such practice would seem to be contradictory to the principle, that post-graduate courses should be organized on an educational basis which demands a well-

planned program of lectures and experience, and for which students should be prepared to pay a fee. While remuneration offered might possibly be a determining factor in choosing a hospital for post-graduate work, it is important that the applicant should realize that the hospital which charges a fee should be better prepared to offer a course of greater educational value.

The length of the course: Existing post-graduate courses vary in length. In principle, the length of any course is determined by the aims of the course, the educational facilities available, the time it takes to profit by such resources, and the amount of training needed for specialization.

The plan of the course: The course should be planned to correlate lectures and practice. Time and opportunity must be given for observation, participation and study; good library facilities are necessary. It is essential that, in the beginning, the student participate in the nursing care of patients to renew her acquaintance with nursing problems and techniques. She should gradually be introduced into the administration, teaching and supervisory responsibilities, by assisting and relieving the nurse in charge. A knowledge of and some experience in related departments are necessary to increase the nurse's understanding and interpretation; these might include the out-patient department, the therapy departments, health facilities as offered in the hospital and in various health agencies in the community. While the time spent in the service must be sufficient to gain a full understanding of the nursing problems, and to give adequate practice in administration, teaching, and supervision, it must not overbalance the time necessary for studying in connection with lectures, and other educational aspects of the program.

Evaluating the student and her work: Evaluating the nurse should be a continuous process, rather than in the na-

ture of a final test. The supervisor assigned to the teaching and supervision of the post-graduate student should feel a definite responsibility in helping the student to evaluate herself and her work. The student should be judged on her increased knowledge, nursing proficiency, ability to administer the department, to teach and to supervise successfully. If her course proves to be of real value, at its conclusion, the nurse should manifest increased interest, have better established habits of performance, greater self-confidence, more mature judgment and the ability to assume greater responsibility.

Certification: The awarding of a certificate is recommended for courses which meet the full requirements of post-graduate work. Such certificates should be signed by the properly constituted university and hospital authorities.

A NEW EXPERIMENT:

This article has been prompted by the fact that a new post-graduate course in psychiatric nursing has been approved by McGill University and the Allan Memorial Institute of the Royal Victoria Hospital. It will be directed by the School for Graduate Nurses. This full year course is to be organized on a sound educational basis consisting of a closely correlated program of lectures in the university, and advanced professional knowledge and practice relating to psychiatry and psychiatric nursing.

Nurses will be accepted into the course who are graduates of good schools of nursing; who meet the university entrance requirements; who have had satisfactory experience in psychiatric nursing and who have demonstrated ability and suitability for specialization in this field.

International Council of Nurses

GRACE M. FAIRLEY

One of the objects of the International Council of Nurses reads "The Council aims to provide a means of communication between nurses of various nationalities, to provide opportunities for them to confer upon questions relating to the welfare of their patients and their profession, and to afford facilities for the interchange of international 'hospitality." For these very reasons and, no doubt, because of the trend in world affairs, the president, Miss Effie Taylor, considered it timely and essential to call a conference of available members recently, to study existing needs of those member countries which have suffered so deeply and personally during the past five years and which in very deed must be giving continuous thought to the health and welfare of their citizens. The

meeting was held in New York, and, as previously reported in the *Journal*, six countries were represented. It was significant of the 'Spirit of Nursing' that there was a truly international theme in the discussions of the most urgent needs of the countries which have participated in or been affected by the tragic world encircling war.

The question was, what can the I.C.N. do to help? — in health education, in assisting in rehabilitation programs, creating post-graduate opportunities, procuring first-hand information as to immediate professional needs, as well as the planning of a sound, progressive and democratic program for the future of the profession. These were the main items on the agenda. It seems fitting, therefore, that at this time we should

review the history of the International Council of Nurses and its accomplishments since its inauguration on July 1, 1899.

The seed of "The International Idea" was sown at the Chicago Exhibition in 1893 when Mrs. Bedford Fenwick of England arranged a nursing exhibit for the British Government. However, it was not until 1899, when the International Council of Women met in London, that nurse delegates from several countries were called together by the Matrons' Council of Great Britain and Ireland under the able leadership of Mrs. Bedford Fenwick. At this time, the International Council of Nurses was founded by that great woman. This historical meeting was held at 20 Hanover Square and the late Miss Isla Stewart, president of the Matrons' Council, was in the chair. At this meeting Mrs. Bedford Fenwick, in a few eloquent words stressing the value of organization and the brotherhood of man, stated that surely "a sisterhood of nurses is an international idea and one in which the women of all nations could be asked and expected to join". She then proposed the following brief motion "that steps be taken to organize an International Council of Nurses". Thus, with simplicity and dignity this great organization was founded.

The charter member countries were: the United States of America, Britain and Germany, and the other countries which were admitted in those early days were Canada, Denmark, Finland, and Holland. India and New Zealand were admitted in 1912.

On May 5, 1900, a meeting of the provisional committee was held at St. Bartholomew's Hospital, London, when the following officers were appointed: president, Mrs. Bedford Fenwick, Great Britain: honourary secretary, Miss L. L. Dock, United States of America; honourary treasurer, Miss M. A. Snively, Canada.

In September 1901, at Buffalo, the

first Congress of the I.C.N. was held and subsequent meetings were as follows: 1904, Berlin; 1907, Paris, interim conference; 1909, London; 1912, Cologne; 1915, San Francisco. The congress was abandoned owing to war but a small informal meeting was held when Miss Annie W. Goodrich presided. 1922, Copenhagen, meeting of Grand Council; 1923, Copenhagen, meeting of executive committee; 1925, Helsingfors, Congress; 1929, Montreal; 1933, Paris and Brussels; 1937, London. A conference was held at Atlanta, Ga, in the Spring of 1920 for the purpose of studying "the international outlook".

One has but to read the reports of committees and the resolutions adopted at these conferences and congresses to be conscious of the development of nursing education in all professional fields and in many countries. The exchange of views and policies between nurses of countries which had well-developed health programs was definitely stimulating and reassuring, while the advice and assistance given (at request) to countries where for want of trained leadership the health of the people or the education of nurses might have progressed less quickly, was both kindly and helpful. Individual nurses as well as national organizations were stimulated by the international friendships which had their roots at such congresses. It is to the women whose names appear in the early records that we owe a debt beyond words for the professional status of nurses both nationally and internationally. They were business-like, and the provisional committee prepared a constitution which was adopted in July, 1900. With few alterations that constitution carried through till 1925. A revision was printed in 1937 and at the present time a committee is at work on recommendations which it is hoped will be submitted at the first congress following the cessation of hostilities. In the historical record published at the conclusion of the Constitution and By-laws we find the names of the nurses whose foresight and imagination led to this great "International Idea" which the founder referred to in her preamble.

Of special interest to the C.N.A. members in addition to the name of the founder, Ethel Bedford Fenwick, are the names of the late Miss Annie Murray and Miss Mary Agnes Snively as Foundation members and councillors. One has but to glance at the programs of these meetings and note the dates to realize the vision these women had for the future of the nursing profession. For instance: 1901-"A plea for the higher education of nurses", Mrs. Bedford Fenwick. Quoting from this paper, "I claim that the time has come when nurses need their educational centres, their endowed colleges, their chairs of nursing, their University degrees and State registration". Does this not sound very familiar to the nurse of 1945? 1912 — Cologne: "The overstrain of nurses", "the duties of the Matron in administration", "the duties of the Matron in the training and education of the nurse", "trained nurses in social service".

It was at the Cologne Congress in 1912 that the question of a "Florence Nightingale Memorial" was officially presented. The matter was introduced by Mrs. Bedford Fenwick who said she had "the honour to propose - that steps should be taken to institute an appropriate memorial to Miss Florence Nightingale. Miss Nightingale was above all nationality, and belonged to every age and every country". Her proposal was "that nurses of the world should cooperate to found an educational memorial, in memory of Miss Nightingale, which would benefit nurses of the world". Miss Agnes Snively, a past president and founder of the Canadian National Association of Trained Nurses, was one of the councillors to speak in support of the suggestion. She expressed "complete sympathy with the proposition" and added that she believed

that a memorial, educational in its nature, was one which Miss Nightingale would have approved. A committee was appointed but it was not until 1932, when the League of Red Cross Societies found it necessary to abandon the international post-graduate which it had financed since the cessation of the Great War, that it was suggested that the I. C. N. might develop this already-organized plan as a memorial to Florence Nightingale. A meeting was called in July of that year and certain recommendations advanced which were finally adopted at the 1933 Congress, and thus the Florence Nightingale International Foundation (known as the F. N. I. F.) was inaugurated. The League of Red Cross Societies had certain assets such as the residence in Manchester Square (later known as International House) and certain monies which they were willing to hand over to an independent Board comprised of representatives of the League of Red Cross Societies and the Board of the International Council of Nurses. Like the I.C.N., the Florence Nightingale Memorial is an international organization comprised of national committees and these committees are made up of equal membership of the Red Cross Society and the National Nurses' Associations. For instance in Canada the committee is known as the Canadian Florence Nightingale Memorial Committee and has at present three representatives named by the Canadian Red Cross Society and four (including the secretary) named by the Canadian Nurses Association.

At the recent meeting in New York much thought was given to the reorganization of the F.N.I.F. so that the rapidly changing needs of nurses from all countries will be adequately met in any plan of reconstruction. Since 1939 International House has been demolished. Whether it will be rebuilt as a residence or as an administrative centre must await the decision of the mem-

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bers at the next congress. Opportunities for post-graduate study in many countries have been developed since the inauguration of the "International" course at Bedford College and it will not be surprising if, in future, the Florence Nightingale Foundation more nearly parallels other educational foundations and makes it possible for nurses to secure opportunities in advanced professional education in any country where such recognized courses are available. Twice since the founding of the I.C.N. the world has been plunged into war and for a number of years nurses have had but limited contact with their professional sisters in other countries, but true to the tradition of the I.C.N. we are sure the nurses of all member countries look forward to that day when peace will be restored and we can again meet and confer on professional problems and advancement. Our president, Miss Effie Taylor, has left no stone unturned in her efforts during the past five years to keep in close fellowship with the nurses of those lands where postal or cable contact has been possible and to her nurses of the world owe a debt of gratitude and also look to her to speed the day when it will be possible to meet again.

I.C.N. headquarters are in London. England, but at the outset of war it was considered essential to open a temporary office in the United States of America at Yale University (the residence of the president). Early in 1944 plans were made for the transfer of the offices to New York. They are now at 1819 Broadway, Columbus Circle, adjacent to A.N.A. headquarters. These new offices are central and in every way readily available to members from various countries who are visiting New York. Miss Effie Taylor, president, and Miss Anna Schwarzenberg, secretary, are always glad to welcome nurses from any other country and assist them in arranging post-graduate courses or other professional contacts.

In the minutes of the 1904 meeting of the I.C.N. at Berlin it states that the members have been striving to forward its objects — the promotion of greater unity of thought, sympathy and purpose, of international communication between nurses and of International Conference. What greater contribution can the nurse of today make than to help in the furtherance of international standards of nursing and a deeper understanding among the nurses of the world?

Eminent Medical Health Official Back in Britain

Word has been received of the arrival in England of Dr. George F. Buchan, medical officer of health for Willesden, London, England, who recently completed a coast-to-coast Canadian tour under the auspices of the Health League of Canada.

Dr. Buchan spent a strenuous time in the Dominion. He addressed service clubs, medical societies and other organizations and visited medical officers of health and hospitals in most of the numerous Canadian cities and towns he visited. He touched Vancouver on the west coast and Charlottetown in the east.

Dr. Buchan had praise for Canadian health institutions and special commendation for health workers in the sparsely-populated areas. One of the tour highlights was a radio broadcast over the CBC's trans-Canada network from Montreal. In this address he said the British people are determined to eliminate poverty and unemployment in their time, and above all they wanf good health to enable them to attain and enjoy good housing, decent living conditions, adequate nutrition, and time for rest, reflection and recreation.

Steps Britain had taken would provide

better health services and greater social security for the future, he said, and predicted that a bill for National Health Service would no doubt be put before parliament in due course. The government proposed to include all services in a comprehensive health plan.

Dr. Buchan emphasized that the health of the British people was never better than at present and that, despite bombings which created unfavourable health conditions, there had been no epidemics.

-Health News Service.

A New Plastic Eye

A new plastic eye is being made by the United States Army which is lighter and more durable than glass and can be tinted to duplicate the appearance of the natural eye and fitted to provide as much motility as possible, thereby avoiding the appearance of staring.

First step in making the eye is to paint the "iris" — a thin celluloid disc, only oneten-thousandths of an inch thick. The "iris" is then embedded in a tiny plastic lens of acralain — a plastic that has been used in dentistry for the last ten years.

The impression of the patient's eye socket is made with a new type compound, an alignate plastic, that is chemo-setting. This, mixed with water to make a paste, is injected with a syringe under the eye-lid at body temperature without causing pain or discomfort. It sets to a rubber-like consistency in five minutes and is removed painlessly, giving a permanent record of every tissue contour within the socket. A plaster cast is then made from this replica and used to mold a wax model of the eye-ball. The iris

button is fitted into the wax and the whole unit is then fitted to the patient. The body temperature melts the wax slightly to produce an even better fit.

A second cast is then made from this wax replica, the wax is melted away and the cavity filled with acrylic resin, tinted the shade of the patient's natural eye-ball. This is baked for an hour under a half ton of pressure. When it comes from the cast it has on its front surface the tiny disc of the iris. It is then polished and the "veins" are applied — tiny rayon fibres, an innovation by Captain Don Cash of Beaumont General Hospital, El Paso, Texas.

As a final step, the whole eye is dipped in a clear plastic solution which produces a gleaming coating similar to the layer of liquid covering the natural eye.

This plastic eye is so durable it can be dropped on the floor and stepped on without injury.

> Office of the Surgeon General Technical Information Division Washington, D. C.

Previews

In the rapid development of industrial health divisions, the management has played an important part. R. M. P. Hamilton, president of the General Engineering Company Ltd., has described the inter-relationship that must exist for the successful growth of this type of service.

What should be included in the course

in microbiology for student nurses? How elaborate does the laboratory equipment need to be? How can the whole course be related to the students' actual ward experiences? Blanche McPhedran who has been most successful in her instruction of this subject, will answer these questions for us in the April number.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses
Association

Problems and Difficulties in a Tuberculosis Program

GEORGINE BADEAUX

I am to speak to you today of some of the difficulties that face public health nurses in the field of tuberculosis in Montreal, and I shall endeavour to tell you in simple, everyday language what our visiting nurses are doing in homes where there is an active case of tuberculosis.

Difficulties there are and perhaps will always be in tuberculosis work. Fortunately, I am not called upon to solve all problems, but rather simply to report on what has been my daily experience in home visiting over a period of years.

The health worker, whether in tuberculosis or some other field, is primarily concerned with education. When the visiting nurse enters the home, it is as a teacher, to demonstrate both theory and practice. She instructs the family in the principles of healthy living and impresses upon them the importance of making good health habits a daily routine.

Tuberculosis has been widely publicized. The public has been told of its prevalence, the dangers attending it, and its manner of spread. In spite of this, in some households we find antagonism and misunderstanding of our motives.

The chief difficulty has to do with the attitude of the family or household with regard to our visits. In some cases, there is an unreasonable fear of the disease, with the result that the patient is neglected. Others are reluctant to believe

that tuberculosis is a serious disease, and so treatment is delayed and contacts are unnecessarily exposed to infection. Early admission of the patient to sanatorium offers the best means of solving these problems because, in this way, the patient is assured of the necessary treatment and the contacts are protected through removal of the source of infection. Some individuals, notwithstanding Pasteur and his wonderful discoveries, actually doubt the existence of germs! Our methods in health education must be such as to overcome ignorance and prejudice concerning essentials. It requires a great deal of persuasion to get families to admit to a previous case of tuberculosis in the family circle, thus increasing the worker's difficulty in tracing the probable source of infection. In the majority of cases, it must be said, however, that families are co-operative and sincere in their desire to do what is best for the patient. They are easily convinced that sanatorium treatment is the chief factor in cure.

Another great difficulty has to do with the home treatment of a case of tuberculosis. Such treatment is seldom successful. Houses are overcrowded, and a separate room, or even a bed, frequently an impossibility. Many homes have no provision for rest in quiet surroundings, with ample sun and fresh air. The rhythm of family life in war-

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time is vastly different from what it was before the war: night is turned into day, and working, sleeping and eating habits are reversed. All this in a small flat where there is barely elbow-room! How can an ambulant pneumo-thorax case secure the necessary rest in such an environment? And the outlook is even less favourable for the patient who is confined to bed.

Dr. Samuel C. Stein₁ states: "The prevalent opinion that the finding of active tuberculosis in a minimal stage warrants an excellent prognosis is true only if qualified by the statement 'if adequate treatment is taken' . . . The number of minimal pulmonary tuberculosis cases in sanatoria has not increased in direct proportion to the number of cases found." He points out that on admission to sanatorium 50 per cent of patients were much more ill than they were at the time diagnosis was made. He attributes this to delay in admission to sanatorium and to the rapid progress of the disease.

We are left with no illusions concerning success in the home treatment of a case of tuberculosis.

As regards tuberculous children, the question of maternal authority gives rise to a difficulty because frequently such authority is conspicuous by its absence. Mothers loudly bewail their inability to keep one child in bed while his brothers and sisters are out playing. A recent article2 maintains that the preventorium is not an indispensable institution. Others have said that it is possible to carry out the treatment of a tuberculous child in normal family surroundings. This theory does not hold when applied to large families in homes with inadequate sanitary facilities and, practically, it is not within the powers of the visiting nurse to effect the improvement of sanitary arrangements, nor does it depend solely on the intelligence and good-will of the parents.

Today, the greatest number of tuberculous patients realize the necessity for

and desire sanatorium care. We may perhaps take some credit for this attitude since we continually stress the benefits of institutional care both for the patient and the family. Unfortunately, there are insufficient beds available, the long wait for admission to sanatorium cools the patient's ardour, our educational efforts are undone, and we hear such statements as: "If the disease were communicable to the extent you claim, a bed would have been found for me long ago". Finally, if and when a bed is found to be available, the patient frequently refuses to go to sanatorium, with the inevitable result.

One of our important duties is to arrange for the examination and periodic re-examination of all contacts. Our percentage of such examinations parallels the figures of a survey made in New York States namely 48 per cent. Montreal is gradually developing more and more facilities for clinical and x-ray examinations, and we are happy to report correspondingly better results in this respect. In mentioning this figure of 48 per cent, it may be well to point out that this does not mean that 52 per cent of our contacts are not examined, but rather that 48 per cent of them are being supervised whereas the others are not. Many contacts are under the supervision of the family physician, and some are examined at their place of employment. Others still are attending and are being supervised by the outdoor departments of general hospitals and so claim assurance of a clean bill of health as regards pulmonary tuberculosis.

Not the least of our difficulties are those associated with the social and economic life of the families we visit. Many of these people live from day to day on a minimum wage. If bed-rest is prescribed, if the patient is in a rooming-house without help of any kind, if he is the bread-winner of a large family, there are many social and economic features to be considered. Sometimes, children are to be placed in boarding homes;

again, mothers' allowances are to be applied for, or, to meet immediate needs, direct relief is to be secured from the parish branch of the St. Vincent de Paul Society. Usually it falls to the visiting nurse to make these approaches, necessitating innumerable visits, letters and telephone calls. Social legislation, when restricted to the letter of the law, may be inapplicable to a particular situation, such as the case of an indigent mother who has not resided in the province for seven years or more and who is not, in consequence, eligible for provincial assistance. Another case is that of a young man who insisted on leaving sanatorium to go back to work because his family, though indigent, had lived in the province for only four years and so were not entitled to financial help from the province. These matters can generally be adjusted, but in order to secure special consideration for them there is much work to be done, the quantity of which is not measurable although it is essentially part and parcel of the effective handling of a case of tuberculosis.

The visiting nurse, by virtue of her calling, is also the confidante of her patient and the family, and her advice is sought in a wide variety of physical and mental ills. Many of these are beyond her power to adjust, but her sympathy and tact will do much towards making the burden easier to bear. The extent of help given in this way can never be estimated, and yet its value to the patient and the family is without question.

We follow our patients through every stage of the disease whether the prognosis is favourable or unfavourable. We act on reports received from our own medical staff, from family physicians, and from hospital clinics. We are pleased to co-operate with the doctors in interpreting their advice to their patients, and we are particularly appreciative when the doctors' recommendations are given in clear and explicit language.

There are patients who leave sana-

torium of their own accord, and there are others who are intractable and dissatisfied. It is difficult to persuade these individuals to remain under supervision. They disregard our notices to report for examination and, in time, despite our efforts, we lose track of them.

An article, which appeared in Public Health Nursing in 19414, states that several sanatoria in the United States reported that 66 per cent of their patients left sanatorium contrary to medical advice. Partial responsibility for this was placed on the sanatoria for various reasons, such as: failure to employ adequate medical and nursing staff, insufficient provision for rest, lack of privacy, over-activity for early cases, disregard of aseptic measures, and even tacit encouragement of the patient to leave sanatorium. It would appear that these non-arrested cases are responsible for increasing the number of re-admissions by from 20 per cent to 25 per cent. I do not know if comparable surveys have been made in Canada.

These are some of our difficulties. Trudeau has said: "On the spirit of a work like this depends its success." Will the spirit of the tuberculosis work that is being done in Montreal lessen our difficulties and ensure success? We devoutly hope so!

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Le service social de l'Institut Bruchesi: Ses difficultés

Je suis encore étonnée de l'honneur que vous me faites de me mettre au programme aujourd'hui. J'en suis aussi émue, impressionnée, parce que je pose un acte de responsabilité vis-à-vis un travail qui tient en haleine les travailleuses sociales en tuberculose, à Montréal.

Vous voulez bien vous reposer de données scientifiques et savantes pour suivre au service social, dans un domaine pratique et quelquefois prosaique, les infirmières-visiteuses que vous déléguez dans les familles après un diagnostic?

Je suis invitée à vous parler de nos difficultés, s'il est humainement impossible de n'en pas avoir du tout, jusqu'à quel point la société et nous-mêmes pouvons-nous les diminuer? Je ne suis pas, par bonheur, appelée à apporter des solutions mais bien à exposer des difficultés vécues, réelles, que des observations, des réflexions ont localisées dans les visites à domicile pour moi journalières depuis des années.

Le travail de l'hygiéniste, que ce soit en tuberculose ou dans une autre spécialité est essentiellement un travail d'éducation. Quand une infirmière, pleine d'enthousiasme frappe à une demeure, elle vient donner telle ou telle instruction, elle vient enseigner, prouver, faire admettre telle ou telle bonne habitude d'hygiène pour que cette famille la vive, l'incorpore dans sa routine, pour qu'elle en fasse une assimilation parfaite, alors seulement il y a éducation.

On a beaucoup fait pour l'éduction populaire en tuberculose: on a publié, prôné sa connaissance, ses dangers, sa contagion, mais nous rencontrons encore des réactions familiales qui font obstacle à notre travail.

Première difficulté, donc, réaction de la famille ou de l'entourage. On a une peur irraisonnée du malade, ou on refuse de le croire malade. Dans le premier cas, le malade est persécuté; dans le second cas, son traitement est differé et les contacts sont fortement exposés à la contamination. L'hospitalisation immédiate sauve les malades dont on a peur, et l'hospitalisation immédiate protège les contacts du malade dont on refuse de reconnaître l'état morbide. J'ai entendu un raisonnement plus simpliste et incroyable en 1944. "Pauvre Garde, vous croyez à ça vous aux microbes? Moi, je ne m'en fais pas, je n'y crois pas". Pour celle-ci, Pasteur

n'est pas né . . . elle en est encore à la génération spontanée. S'il nous faut observer le principe qui demande d'adapter notre enseignement au niveau du developpement où en sont rendus nos gens, ce qu'il faut remonter de loin des fois, et c'est pour convaincre de choses élémentaires, naturelles, pour nous indiscutables, que nous avons pénurie d'arguments. Quelques préjugés subsistent aussi: on n'avon pas facilement les anciens cas de tuberculose dans la famille . . . quelle adresse faut-il alors déployer pour découvrir la source probable de contamination.

Dans la majorité des cas, la famille affligée d'un malade veut sincèrement sa guérison, souhaite l'hospitalisation qui est l'espérance du rétablissement prochain, à son avis, et montre une bonne volonté évidente aux exigences de notre enseignement.

Mais deuxième difficulté, la cure à domicile est matériellement et socialement impossible, toujours dans la majorité des cas. Les maisons et même les lits sont surpeuplés. Peut-il être question de chambre seule, ensoleillée, à une ambiance calme, reposante, à une aération régulière et bienfaisante? La vie familiale n'a plus le rythme d'avantguerre, on dort le jour, mange et travaille la nuit, dans un logis exigu où l'on se serve les coudes, quelle cure attend notre malade? A peine si les cas ambulants de pneumothorax peuvent-ils décemment se reposer un peu.

Le Docteur Samuel Stein écrit dans une revue américaine "The Public Health Nurse" ce qui suit: On attache beaucoup d'importance au diagnostic précoce en tuberculose comme facteur de guérison, mais encore faut-il ajouter, oui, si le traitement opportun est institué immédiatement. La proportion des malades dépistés au début, continue le Dr Stein, n'est pas relative à l'admission de cas de début dans les Sanatoriums. A leur entrée aux Sanatoriums, 50 pour cent des malades sont plus malades qu'à l'époque de leur diagnostic. On attribue la cause au retard à l'Hospitilisation, à la faible résistance du contaminé et au progrès rapide de la maladie dès le début de l'infection.

Et nous n'avons plus d'illusion sur la possibilité d'une cure-traitement vraiment efficace à domicile.

Pour les enfants tubercule k, soumis à la

cure, il y a la question d'autorité maternelle qui entre en cause, parce qu'elle est souvent absente. Les mères nous certifient avec volubilité leur impuissance à tenir un enfant au lit tandis que ses frères et soeurs s'amusent. Un article d'une revue américaine affirme que préventorium n'est pas indispensable, qu'un enfant tuberculeux est appelé à guérir en régime de vie normale. Cette assertion vaut-elle pour nos familles nombreuses de conditions sanitaires déficientes? L'amélioration des conditions sanitaires ne dépend pas exclusivement de l'hygiéniste ni même de la compréhension et du bon vouloir des parents.

Les malades récemment diagnostiqués désirent l'hospitalisation: nous leur en vantons ses avantages pour lui et pour les siens et l'attente émousse leur décision quelquefois héroique; nous perdons du terrain, notre prestige diminue, le malade finit par dire: "si c'était aussi contagieux que vous le dites, Garde, on m'aurait trouvé une place" et il refuse le lit qu'on lui offre . . . si on lui offre un jour . . . avant le trépas . . .

Nous poursuivons inlassablement le but d'amener à l'examen et à l'examen périodique tous les contacts. Notre pourcentage de contacts examinés rencontre le chiffre d'une enquête faite aux Etats-Unis, soit 48 pour cent. Montréal a de récentes facilités d'examen clinique et radiographique et Dieu merci, notre travail a plus de résultats.

Un mot, à propos du chiffre de nos contacts examinés. Il ne veut pas dire que 52 pour cent des contacts ne sont pas examinés. La vérité est que 48 pour cent des examens de nos contacts sont contrôlés, les autres, pas. De nombreux contacts vont chez leur médecin de famille ou sont examinés à leur travail, ou, encore, inscrits et suivis dans les dispensaires de nos hôpitaux généraux, ils affirment avoir l'assurance d'être sains au point de vue T.B. pulmonaire.

Permettez-moi une parenthèse pour vous expliquer les statistiques et citations américaines. Je dois aux administrateurs de l'Institut Bruchési l'avantage d'avoir suivi un cours de perfectionnement à l'Université McGill, d'octobre à février. Les étudiantes avaient la liberté d'employer le dernier mois à l'étude d'une spécialité, d'en faire une bibliographie, etc. Inutile d'ajouter que je me suis consacrée aux problèmes médicaux-sociaux de la tuberculose; c'est à cette source de renseignements que je puise aujourd'hui.

Nous avons à faire face à des difficultés d'ordres économique et social dans nos familles visitées. La plupart de nos gens vivent au jour le jour, du salaire courant. Si le malade est mis au repos, et s'il est en chambre, sans secours; s'il est le gagnepain d'une nombreuse nichée, maints problèmes se posent. Accepte-t-on le placement familial pour les enfants? Ou fait-on les démarches en vue d'obtenir assistance de la Pension des Mères Nécessiteuses? Le secours immédiat est assuré par la Société de St Vincent de Paul paroissiale, mais l'infirmière sollicite souvent pour la famille que manque de ébrouillardise; elle recommande; elle multiplie les démarches ordinaires et quelquefois extraordinaires. Une loi sociale peut par sa constitution devenir inopérante dans certaines circonstances. Voici un exemple entre plusieurs: Une mère nécessiteuse qui ne réside pas dans la Province depuis plus de sept ans n'a pas droit à l'assistance provinciale. Dernièrement un jeune père de famille voulait sortir du Sanatorium, se remettre au travail à cause de l'indigence dans laquelle se trouvait sa famille établie dans notre province depuis quatre ans seulement. L'infirmière écrit au Président de la loi à Québec, sa lettre est remise au Ministre du Travail, et celui-ci, par considération spéciale accorde enfin la pension. Voici du travail qui n'apparait pas dans les statistiques annuelles, et qui est courant, intimement lié, adhérent au problème tuberculeux.

Les confidences que nous entendons généreusement révèlent bien des tares physiques et morales. Nous ne pouvons pas tout solutionner, mais combien adoucir des épreuves ou à faire s'y résigner. Autre travail n'invoquant pas d'expression quantitative et qui a une telle importance pourtant.

Il nous est utile de suivre nos patients dans leurs étapes vers la guérison, comme hélas, vers l'aggravation de leur état. Au point de vue médical, au point de vue traitement, les directives nous arrivent des médecins consultants; nous les lisons sur les dossiers, ou nous les recevons avec plaisir des cliniques voisines. C'est évident que nous doublons vos conseils, vos enseignements, Messieurs les Médecins, que nous argumentons, expliquons les hienfaits de vos prescriptions, c'est pourquoi nous apprécions tant les ordonnances claires et énergiques.

Les malades qui sortent sans congé des Sanatorium, les indisciplinés, les mécontents sont difficiles à ramener aux examens de contrôle. Ils nous échappent littéralement.

Vers 1940 on fit une enquête dans les Sanatoriums américains. Quelques institutions ont rapporté que 66 pour cent de leurs patients quittaient l'hôpital sans avis médical. On impute aux Sanatoriums ou institutions une bonne part de responsabilité. Les Sanatoriums n'emploieraient pas suffisamment de médecins et de gardes-malades qualifiés; les patients n'y auraient pas le repos nécessaire; il y existerait une promiscuité désagréable; les cas de début auraient trop d'activité; il y aurait peu d'attention à l'asepsie, enfin, fréquemment on justifiait les malades de quitter les Sanatoriums. Ce sont sans doute ces non-guéris, ces non-améliorés qui grossissent à 20, 25 pour cent le chiffre des réadmissions dans les Sanatoriums.

Je ne sais pas si enquête semblable a été faite au Canada; nos voisins du Sud sont sans doute plus que nous, friands de chiffres.

Il faut que je me sente vraiment en confiance pour aborder la question de nos pauvres malades recevant des traitements, des opérations que je qualifie, "orthodoxes" n'en connaissant pas la portée scientifique. Il y a ici un maniement délicat qui nous ennuie. Nous ne voulons pas ébranler l'espérance du malade qui, économiquement se gène pour s'assurer, croit-il, une guérison infaillible. Mais jusqu'à quel point faut-il feindre d'abdiquer nos théories sagaces, n'est-ce-pas? . . . devant des faits incontrôlables, frustant nos gens au moins d'un côté?

Dilemme médical et social qui nous afflige et qui clôt ici l'énumération de nos plus grandes difficultés.

Trudeau a dit: "Le succès dépend de l'esprit avec lequel le travail est fait". L'esprit du travail qui se fait à Montréal, en tuberculose diminuera-t-il nos difficultés? . . . c'est à espérer.

Je vous remercie de votre généreuse attention que vous accordez sans doute à l'accent de sincérité qui m'absout peut-être d'avoir osé retenir un auditoire, trop qualifié pour être qualifiable par moi.

Blood Donors Needed

There is nothing which can be done here at home of more importance than to offer blood for the life-giving work of the Canadian Red Cross. It is unthinkable that any young men whose lives will depend on adequate and immediate supplies of dried blood serum should lose their lives because of our failure — the failure of the Canadian people, here at home, to donate at Canadian Red Cross blood donor clinics.

The need for new donors still exists. Recently the Ontario Division inaugurated a campaign for 50,000 new donors in Ontario. With the lives of many servicemen overseas depending on the continued supply of plasma (serum) the Division's executive had been greatly concerned with the dropping off in donors. The fact that a great many of the clinics had been calling up donors regularly in eight weeks was also a matter of grave concern. The ruling is that

donations should be spaced at a minimum of eight weeks, but that not more than five donations should be made each year. It is early yet to estimate the complete total of new donors who have signed up, but 5000 donations of blood daily are needed throughout Canada to assure an ample supply.

Red Cross files bulge with letters from returned men who freely acknowledge that Red Cross plasma saved their lives. Corporal Fred Cooper, now back in Brockville, unhesitatingly ascribes the saving of his life to a combination of blood transfusions and skilled surgery. He says "there is no finer war service for Canadians at home to render than to give their blood at Red Cross clinics. Won't you enrol for this vital service NOW? Failure to provide all the blood needed would be a military disaster of the first magnitude.

-KATHLEEN NAIRN

R.N.A.O. Annual Meeting

The Registered Nurses Association of Ontario are arranging for their annual meeting to be held at the Royal York Hotel, Toronto, on April 12, 13, and 14, 1945. The program is not yet completed but a copy will be sent to all members as soon as possible.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A

Clinical Instruction in the Operating Room

MARY EICHEL

There still appears to be a question in the minds of many members of the nursing profession as to whether operating room work is a special field or whether it is a part of basic training. We are not skilful nurses if we do not apply technique to all our nursing care in every field of nursing, and exquisitely skilful nurses we want to be.

The operating room experience is placed at the end of the first year or beginning of the second, primarily to give the student intensive practice in the technique of surgical asepsis and also a better insight into the conditions of surgical patients and the relation of the operation to the patients' nursing care. The student will have had her lectures in surgery and surgical nursing.

A period of not less than three months is spent in the department, preceded by ten hours of theory, and this period includes eye, ear, nose and throat surgery, as well as observation in the cystoscopic rooms. In this time the student achieves the fundamentals of technique, she learns how to become a good circulating nurse, learns how to drape. She should have sufficient scrubs to make her familiar with sutures and needles used. She should learn the names of instruments and the methods of sterilization. She is taught how to care for property in the operating room as equipment is expensive, supplies are costly.

It is imperative that procedures common to all departments be standardized throughout the hospital. This simplifies technique for the student, she places greater value on it, and it facilitates instruction.

In our profession, a sense of the value of human life must be uppermost in our minds, overwhelmingly so in the operating room. The student must be acutely aware that she and others are directly responsible for the life of a patient. If we restore his health and send him home to his family well and happy, we feel our duty has been well done.

There are certain essential qualifications for a good operating room nurse. Among them are such characteristics as self-control, unlimited patience, honesty,



A class at the Winnipeg General Hospital.

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THE CANADIAN NURSE



Preparing the instruments

dependability, keen power of observation and a good sense of humour. All students cannot reasonably be expected to possess all these qualities, but it is our duty to develop them as much as possible.

The best classroom for operating room instruction is the operating room itself. A tactful and adequate introduction helps to dispel the apprehension that a student so often has when she enters the department. The length of time spent in orienting the student depends on the size of the department. A most complete period of orientation must be planned before the student is called upon to perform any function in the operating theatre. A situation in which a student is made the victim of embarrassment often paralyzes a potentially good student. She should be made to realize that she plays an important part in the smooth running of the department.



Scrubbing up

It is essential to introduce the student to operating room procedures at a rate which she can assimilate, to provide practice under supervision and to enlarge her experience with her expanding ability. As her training progresses the student will gain confidence, show more initiative, and will learn to make decisions more readily which will stimulate quick thinking in an emergency.

In the senior weeks of her term in the operating room when she shows sufficient development she should be given charge of one theatre where minor surgery is done. Pushing a student to greater responsibilities before she is prepared to accept them is not desirable as it gives her a sense of insecurity and lack of ambition. Senior students should be given an opportunity to assist in teaching junior students. Every opportunity for educational discussion should be grasped. Individual instruction is so often necessary and in such a busy department it is the best method of teaching. Group conferences and practice periods are excellent and should be carried out routinely. Appropriate assignments relating to the work should be given.

A systematic recording of student experience must be employed. Clinical experience sheets for each student should include all procedures, scrubs and periods of instruction. Efficiency reports require an adjustment peculiar to the department, for example: (1) adaptability and technical skill as applied to the operating room; (2) responsibility for comfort and safety of patient in the operating room. In order to determine the consistency of theory and practice, records should be kept of marks obtained in theory and efficiency.

A well-organized manual of procedures must be kept in the operating room, also an up-to-date book of instruments used in all cases. The supervisor and instructor must loyally work in close co-operation to achieve a single objective — to provide a sound experience for student nurses in the operat-

ing room. The instructor must be progressive, must maintain and stimulate interest. The value a student gets out of her training depends greatly on the guidance and teaching she receives. It is imperative that, in order to direct a well-planned program of instruction, you must not be overwhelmed with responsibilities of administration, and here we find a very definite place for an operating room instructor.

Let it be our objective then to in-

struct with patience, kindness and a thoroughness that will include a definite and adequate teaching and clinical program, to achieve our purpose of producing good nurses.

You remember Rudyard Kipling's few lines that set forth such an illuminating philosophy of work — "Hard toil, high courage, eternal sacrifice, bitter disappointment, by these things are visions translated and dreams brought to pass".

Does Your Alumnae Need Revamping?

HELEN MORRISON

For years it has been the practice of many hospital Alumnae Associations to meet once a month, worry through the business, listen to a speaker, eat, and go home. There has been little in the meetings to stimulate any thought about the problems of nursing. Last year, the University of Alberta Hospital Alumnae experimented to remedy this situation. It was proposed that we substitute open forums and panel discussions for outside speakers. Investigating material on timely subjects would make members much more conscious of what problems face nurses today. At first a few members were opposed to the idea. They felt Alumnae meetings should be relaxing social evenings. To keep everybody happy a compromise was struck and we alternated the type of meetings. Since then, it has been generally agreed that the discussion meetings are stimulating and successful.

The usual procedure has been as follows: 1. A committee of three or four members is nominated for each meeting. It chooses the topic, and prepares short papers on both sides of the question.

2. Alumnae members are notified of the topics, by mail, so they may come prepared for discussion.

- 3. General discussion follows the presentation of a paper. Committee members keep order.
- 4. Senior student nurses and outside graduates on the staff are invited to attend.

A few examples of topics discussed are: (1) Should married nurses be employed after the war? (2) Should nurses join Trade Unions? (3) Trends in Basic Preparation. (4) Post-war recruitment from non-professional ranks.

We have found that, in spite of a few heated words, intelligent agreement on general principles is usually reached. Take topic (4) above. It was agreed that: standards must not be lowered; partially trained people should be under the control of a responsible body such as the C.N.A.; we would do well to study the B.N.A. Act to see the possibility of action on a national scale.

We have found these meetings are well attended. Members are interested enough to talk long past the usual closing time. We feel that the experiment can be recommended to any Alumnae Association which finds its meetings are dull.

The Early Development of Pediatrics as a Specialty

HAROLD B. CUSHING, M.D.

One of the most amazing and revolutionary changes in the practice of medicine during the present century has been the development of the specialty of pediatrics and the coincident changes in the medical care of children. In the early years of this century there-were no real pediatric specialists in Canada. Now, only forty years later, there are nearly as many pediatrists as all the other specialists put together. Forty years ago there was no children's hospital, and there was practically no teaching in children's diseases in our universities. Graduating doctors and nurses had no practical experience whatsoever in the care of sick children. The only pediatric society in America had forty or fifty members, nearly all general practitioners. Now there are at least a dozen such societies, of which one, the American Academy of Pediatrics, has nearly two thousand members, all certified specialists in pediatrics only.

What was the cause of this astonishing change? There is a superficial and mostly incorrect saying that every specialty resulted from the discovery of a special instrument such as cardiology from the electrocardiograph, urology from the cystoscope, etc. This is certainly not true of pediatrics. Probably the earliest start of the specialty was due to artificial feeding of infants which rapidly became so intricate and complicated that only a specialist could comprehend it. However this may be, later developments showed such remarkable advances that the movement for the recognition of the specialty rapidly progressed.

Let us look for a moment at the curious conditions that existed in Montreal in 1900. At that time there were only two small children's wards in the English-speaking hospitals of the city, of

about ten beds each, and both of these were closed half of the time, either from infectious disease or from lack of patients. No children under two years could be admitted to either of these wards unless accompanied by their mothers, and consequently were seldom admitted. Our forefathers apparently believed that every woman was born with a divine instinctive knowledge of how to care for a child, whether sick or well, and hence the proper place for a sick child was in its own home, where the unfortunate children died like flies. No nurse-in-training had any instruction or experience in child care; they were supposed to be born with the knowledge of it also. No medical student had any teaching worth mentioning on the treatment of sick children; it was taken for granted it was the same as for adults. The only teaching in the writer's time at college consisted of three lectures on infant feeding given by the obstetric department, one on breast feeding (which seems to be rapidly disappearing), one on the differences between human and cow's milk (which everyone has forgotten), and a third on wet nurses, who have become extinct. Some two or three lectures were also given on children's diseases by some physician in the department of medicine, but no student paid any attention to these as there was no examination on it.

Let us consider next the persons who were associated with the early development of pediatrics in Montreal. The earliest and most important figure was Dr. A. D. Blackader, who was the recognized authority here for many years on children and their ailments. He lectured on children's diseases at McGill University from 1891 to 1921. He was truly a remarkable and outstanding phy-

sician. He was a most successful general practitioner and was professor of Pharmacology and Therapeutics at McGill for over twenty years, pediatrics being only a side-line in which he was interested. During his post-graduate study in England, he occupied a position for four months as resident in the Great Ormond Street Hospital, one of the few children's hospitals in existence at that time, and this was probably the origin of his interest in children. He started one of the first clinics for children in America in the Montreal General Hospital, and was one of the founders of the American Pediatric Society. He was always most detailed in his instructions as to the care of a case, and woe betide the mother who failed to carry out every detail. His marvellous knowledge of drugs, resulting from his early training as a druggist, led to a tendency to polypharmacy in his treatment.

The real development of pediatrics in Montreal is concerned largely with the establishment of regular children's hospitals in the city. The first of these was the Children's Memorial Hospital, founded in 1902 by Dr. A. MacKenzie Forbes. Dr. Forbes was a young surgeon, specializing in orthopedics. Failing to find accommodation for his chronic orthopedic cases in the city hospitals, he started a children's hospital for cripples on his own initiative. Possessed of indomitable energy and zeal, he soon made the venture a great success and within a few years the Children's Memorial Hospital developed into a general children's hospital and has become the centre for English pediatric teaching in Montreal.

The first regular specialist in pediatrics in Montreal who confined his work

entirely to children was Dr. F. M. Fry, who started practice as a children's specialist in 1914. Dr. Fry opened the first Milk Station in the city for the oversight of well-babies. He organized the City Milk Commission to secure a supply of pure milk. This was before the days of pasteurized milk, to which Dr. Fry was bitterly opposed, believing that raw milk was an essential for infants. He was the first pediatrist to be allowed to attend new-born infants in the Maternity Hospital. He was appointed lecturer in children's diseases at McGill University in 1923, but being in poor health he retired after one year and the writer was appointed to the position in 1924.

I am sometimes asked if I think this movement has run its course, that there will be a reaction and the fad for having children looked after by a specialist will gradually die out. Personally I do not believe this and see no signs whatever of it taking place. On the contrary the importance of the specialty appears to be growing from year to year. I can clearly foresee the time in the future when no doctor or nurse will be graduated unless they have spent at least one-third of their clinical experience in the study of children and their diseases. After all, children make up nearly onethird of the population, are sick more often and more seriously than the average adult, so why should not proper instruction be given as to their care? Literally millions of human beings are now living who would have inevitably died in early childhood had it not been for the improvements in the care provided during the last forty years. I firmly believe the specialty of pediatrics is only on the threshold of its recognized importance.

Thiamin Feedings React Favorably

In a report published in Columbia University's Teachers College Record, Dr. Ruth Flinn Farrell reveals that mental activities of human beings are increased through a sup-

plemented diet which contains liberal supplies of yeast. She reported further that it was the thiamin (vitamin B_1) in the yeast which caused the greater mental activities.

Interesting People

Major (Senior P/Matron) M. R. Shaffner, R.R.C., of 21 Army Group, 1st Echelon, G.H.Q. North Western Europe, went overseas originally with No. 15 Canadian General Hospital in June, 1940. At that time she was assistant matron of the Unit, and subsequently became Major (P/Matron), When No. 15 Canadian General Hospital went to North Africa in June, 1943, Major Shaffner went with them, and through all the inconveniences of tent living and encumbrances of the weather in that part of the country maintained the morale of her Unit in an exceptionally fine manner. Both the patients and the Sisters benefitted by her



Canadian Military Photo

Major M. R. Shaffner

cheerful manner and her able administration. Shortly after No. 15 Canadian General Hospital moved to the mainland in Italy, Major Shaffner returned to the United Kingdom, where for a short period she was Principal Matron of No. 23 Canadian General Hospital. She saw this Unit through its first stages of settling down to life in this country, and then proceeded with Canadian Section, G.H.Q., 1st Echelon, 21 Army Group, North Western Europe, as Senior Principal Matron. Major Shaffner has carried on her work on the Continent in just as an efficient manner as she worked in the A.A.I. The Units under her have undoubtedly benefitted by her experience gained while she was down there.

The picture is taken of Major Shaffner, outside her tent shortly after 1st Echelon was set up in Normandy. She is wearing the khaki battledress, blouse, skirt and beret, which is worn by our Canadian Nursing Sisters in an active theatre of war now.

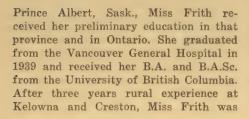
Elizabeth Helen Purdy has retired from her position as supervisor of the Private Patients' Pavilion of the Toronto General Hospital. Miss Purdy, who was born in Kincardine, Ontario, of Irish-Scottish parentage, graduated from the School of Nursing of the Toronto General Hospital in 1905. Ever since her graduation Miss Purdy has been on the staff of her home hospital in various capacities. Because of the extra demands and responsibilities war imposed, she postponed her retirement for several years. Tribute has been paid to her long years of service in a recent series of social events. Miss Purdy has made a hobby of her books and china collections and her many friends wish her joy in her wellearned retirement.

Monica Mary Frith was recently appointed generalized consultant in public nealth nursing with the Provincial Board of Health in British Columbia. Born in

INTERESTING PEOPLE



K. McAllister, Victoria
MONICA M. FRITH





Randolph Macdonald, Toronto ELIZABETH H. PURDY

awarded a scholarship by The Commonwealth Fund of New York for study at the University of Michigan where she received her Master of Public Health degree. At the conclusion of her academic year, Miss Frith received a second scholarship from the W. K. Kellogg Foundation for further field experience.

Obituaries

The Alumnae Association of the Women's College Hospital suffered a great loss in the recent passing of their much loved friend. Mrs. Hannah Mary Ferguson Bowman. Only last August a portrait of Mrs. Bowman was painted and presented to the hospital in celebration of the silver jubilee of the Alumnae of which she was the founder.

Born in Maroposa Township, Mrs. Bowman was a graduate of Clifton Springs Sanatorium in 1908 and later graduated from Columbia University as a registered nurse. Returning to Canada, she became superintendent of Kitchener-Waterloo Hospital at Kitchener, and subsequently Strathroy General Hospital, later going to Halifax as superintendent of nurses at the Victoria General Hospital.

Appointed superintendent of the Women's College Hospital, Toronto, in 1917, she held the position until 1926 when she received the appointment of superinten-

dent of the General Hospital, Newburg, N.Y. She returned to Toronto in 1938 of Ithaca Memorial Hospital, Ithaca, N. Y. She later became superintendent with the idea of retiring, but accepted the appointment of superintendent of Hillcrest Convalescent Hospital, continuing until 1943.

Mrs. Bowman was a past president of the Superintendent of Nurses' Association of Canada, and a member of the Victorian Order of Nurses, the Women's Canadian Club, and Wychwood Presbyterian Church.

Faith Tennys Henderson (Holy Cross Hospital, Calgary) died recently in Calgary. Ever since her graduation, Miss Henderson had devoted herself to the care of the Indians on the Sarcee Reserve, being matron of the Sarcee Hospital. An artist, Miss Henderson received recognition for her paintings of pastoral scenes.

MARCH, 1945

Mrs. Minerva Manahan Rendell (Medicine Hat General Hospital) died recently in Greenwood, B. C. Mrs. Rendell was the first matron of the Greenwood Hospital. Despite her seventy years, Mrs. Rendell accepted the challenge of the

wartime shortage of nurses and fouryears ago again assumed the responsibilities of matron in that hospital. She took a keen interest in public affairs and for several years served Grenwood as an alderman.

Book Awards in Nursing Education

With awards totalling \$1500, the McGraw-Hill Book Company is announcing a contest for the most outstanding three manuscripts submitted on nursing subjects before March 15, 1946. First choice will receive \$1000, second choice \$400, third choice \$100. The contest is open to any nurse in any country and persons in other professional fields are encouraged to participate, but manuscripts

must be written in English and on pursing subjects. Manuscripts submitted for an award should be publishable in book form as texts or reference works and should contain not less than 50,000 words. Complete details may be obtained by writing to the Health Education Department of the McGraw-Hill Book Company, Inc., 330 West 42nd St., New York City 18.

Vitamin B Flour

Public health nurses who have been receiving complaints from families whom they have induced to use the enriched vitamin B flours will be interested in some experiments reported in the *Journal* of the Canadian Dietetic Association on the "Use of Canada Approved white flour in ordinary household recipes".

Tests were carried out by students of the Department of Household Science of the University of Toronto and their findings indicate that for most forms of baking, rolls, cookies, muffins and pastries, excellent results were obtained. Gingerbread and cakes were not quite so satisfactory when made from the enriched flour. A slight tinge of colour was perceptible and a characteristic flavour could be recognized, but it was not pronounced and was considered pleasing rather than disagreeable.

Though not fully investigated, doughs made with vitamin B flours seemed to take appreciably more time for the first rising than did that made from general purpose flour. They required from five to ten min-

utes longer. There was no evidence of greater stickiness of the dough made from the enriched flour. Rolls made from it browned somewhat more quickly.

Urge the families to use vitamin B flour for home cooking.

Urgent Need for Nurses

At the recent meeting of the Executive Board of the National Council of Catholic Nurses in the United States, full support was given to a resolution recognizing the urgent and immediate need of nurses for the armed forces. Furthermore, they went on record as deeming it important that due provision should be made for the maintenance of adequate educational standards and staffs in the schools of nursing, which are the normal sources of professional nursing personnel, and for those health agencies and institutions vital to the well-being of the civilian population.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

The nurses of Canada will be pleased to learn that Christmas and New Year greetings were received at National Office from the S. African Trained Nurses' Association; the Swedish Nurses' Association; New Zealand Registered Nurses' Association; International Council of Nurses; the Royal College of Nursing, London. We are indebted to Mrs. Bedford Fenwick, president of the British College of Nurses, for a copy of "Princess Elizabeth at Home", by Lisa Sheridan. This charmingly illustrated booklet has been added to the library.

At the request of the director of the Education Department, Royal College of Nursing, London, England, the Canadian Nurses Association has planned a program of observation and experience in Canada, covering a twomonths' period, for Miss E. Jeanette Merry, S.R.N., S.C.M., recently appointed education officer to the Queen's Institute Nurses, England.

In 1939 Miss Merry was awarded a public health nursing scholarship by the Royal College of Nursing. Due to the war and the consequent pressure of her work in England, she was unable to take advantage of the scholarship until the present time. Miss Merry is a graduate of St. Thomas's Hospital, London, and received the diploma in social studies from Bedford College.

While in Canada, Miss Merry will study procedure in hospitals in Montreal and Toronto, in the Victorian Order of Nurses and in public health departments in Ontario and Quebec. Later she will leave for New York, where she will be under the guidance of the National Organization for Public Health Nursing for a similar period of observation.

Bursaries

Since the last report issued as at September 30, 1944, awards for long and short-term bursaries have been made as follows:

Long-term: (Quebec) Phyliss P. Thompson, Montreal. Short-term: (Alberta) Marie E. Dufresne, Ruth L. Sheppard, Edmonton. (British Columbia) K. Mary Worsley, Victoria. (Manitoba) Ruby A. Dewar, Dauphin; Florence M. Bezdzietny, Eleanor L. Illsey, Jennie G. Kereluk, Winnipeg. (New Brunswick) Dorothy M. Phinney, Moncton; Marie P. Linkletter, Saint John. (Nova Scotia) Lenta G. Hall, Bedford; Dorothy H.



JEANETTE MERRY

MARCH 1945

Watson, Halifax; Jemima M. MacLean, Inverness; Edna M. Downie, Kentville; Beryl MacRae, Stellarton. (Ontario) Mary M. Currie, Campbellville. (P.E.I.) Jean E. Campbell, Charlottetown; Barbara Pratt, St. Peter's Bay. (Quebec) Marion H. Stewart, Brownsburg; Beryl Freed, Elizabeth Hughes, Faith Lyman, Sister Marie Robert, Montreal; Dorothy G. Brown, Sherbrooke. (Saskatchewan) Clara R. Weiss, Girvin; Marion M. Pope, Rosetown.

Field Visiting

Some years ago the executive of the Canadian Nurses Association realized that more direct contact between the C.N.A. and its federated units was desirable, and recommended that consideration be given to the development of the office of a national field secretary. War came, and the activities of the Association have increased and expanded with lightning speed. The appointment of an emergency adviser and the program that she carried out have demonstrated beyond all doubt the value and need of direct and continuous close contact of the national with the provincial associations. Although National Office continues to be an extremely busy centre, it is realized that the staff should endeavour to maintain personal contact with the provinces through the provincial associations.

The general secretary has planned to attend as many of the provincial annual meetings as possible during the coming months, and expects to spend approximately five weeks visiting the western provinces beginning the end of March.

Plans are also underway for the assistant secretary to spend considerable time. visiting in each of the provinces throughout the coming year, for the purpose of obtaining and compiling data relative to nursing service needs which is required for the Postwar Planning Committee. She will also be available for consultation with conveners of all

committees. The point of emphasis in the publicity program will be Vocational Guidance, and it is hoped that it will be possible to arrange conferences with educational counsellors throughout the provinces.

National Conference of Women

Professional and business women's organizations in Great Britain and the United States have been very active during the past few months drafting and preparing blueprints for guidance during the reconversion period. The women of Great Britain drafted a pamphlet "Women Who Work, Their Standards and Status". The Women's Bureau, Department of Labour, Washington, sponsored a conference comprised of officials of thirty national organizations, the result of which has been the setting up of a Reconversion Blueprint for Women. The National Council of Women of Canada has called a meeting in Toronto for the beginning of February, when this subject as it applies to Canadian needs will be dealt with by representatives of various women's organizations, including the Canadian Nurses Association. Further reports will be given on the result of the conference.

British Nurses Relief Fund

During her recent visit to various centres throughout Canada, Miss Grace Fairley, convener of the British Nurses Relief Fund Committee, referred to the work of her committee, and as a result we gratefully acknowledge a donation of \$25 from Miss Dorothy Gunn, 136 Kent Street, London, Ontario.

The following extracts taken from a

letter received from a recipient of the fund bear witness to the value of the establishment of this worthwhile means of assistance:

I feel I must write to you to express my appreciation and gratitude for the benefits I have derived from your Association through the Royal College of Nursing. I have thanked Miss Fletcher and she has suggested I might care to write you and maybe, she says, you would like to know a little of my experience. As you are scarcely in the position to say you are not interested, I must risk boring you with my confidence.

In 1940, I was called up and attached to the British Red Cross Society (Trained Nurses Section) and my first appointment was to join the medical side of the evacuation of children to the Dominions scheme. So ten sisters were sent out with the children to Australia. We were in the hospital and were kept busy all the way out. After landing the children safely, we were sent back to England on various boats with escorts and our party was broken up, just where we could get a berth, so consequently we were unprotected, being chiefly on small cargo ships and a fine target for the Germans.

I was unfortunate enough to be taken prisoner by a German raider, after our ship was shelled and sunk. We were transferred to a prison ship and were two and a half months on the sea with eight hundred men prisoners and eventually taken to France and later on in stages transmitted to Germany. I had quite an insight into German methods. The Gestapo picked up the women (nine of us) and pushed us into civil prisons in transit. I was with my companions in eight of their prisons. We did not see daylight for two and a half months, as we were conducted from one place to another in prison vans and prison trains. We also had the pleasure of being accompanied by police dogs on all occasions. Eventually we got to an internment camp in Wurtemberg, which was not so drastic but still a prison to us.

After two and a half years I was thrilled to be repatriated to England. Unfortunately by this time I had developed a little heart trouble, which required treatment. But my financial distress was caused through, of course, losing everything at sea. I had also

some property which, through the blitz and my absence, sustained damage and loss of business. I found when I returned my furniture had been exposed and also tenants were in my quarters, so considerable amount of concern was attached to this business also. My insurance had lapsed. My health not being too good just then made it more difficult.

It was at this period that the Royal College helped me through your Association giving me a cheque for £100. Well I was so surprised for I didn't think of such generosity from anyone. Anyway I had just got everything straight and got into a new house when this awful menace which we have been putting up with visited me. We had a robot June 26 (1944) in the next road garden, then July 3 we got one in our road and two days after that a terrible one in the High Road. Well, you can imagine I got the full benefit of the blast. I was thrown right down the stairs and the whole house seemed to fall in. I sustained slight injury, sprained ankles and back, but so, so grateful to be whole and not maimed. So once more I have to wait for repairs and gather the remnants of furniture, etc. I had let two flats and lived myself in the ground floor, had just settled in two months and now this! Well, one can't call it monotonous, can they? Again the College has helped me and I am so grateful because I don't want to get in arrears again, if possible.

Do forgive the detail, but one does feel that when good causes are so helpful and attain the object — well please let me say "Thank you very much."

Nurses National Memorial Service

It has been customary in the past to hold an annual vesper service for the nurses of Canada on a suitable date in May. It has been decided to hold the service this year on Sunday, May 6. Arrangements are usually made locally for this memorial service. Whenever possible these are made in co-operation with local units of the Nursing Sisters' Association.

Postwar Planning Activities

Contributed by

POSTWAR PLANNING COMMITTEE OF THE CANADIAN NURSES ASSOCIATION

The "postwar period" of which we hear and talk so much is actually already here. The Canadian Nurses Association has been aware of this reality and the national committee on Postwar Planning has endeavoured to meet some of the requests for guidance and help. The objectives of this committee have already been clearly set forth in the Journal (September, 1944). That all may be informed concerning educational and service opportunities as they develop, announcements will appear monthly on this page.

Rehabilitation is already in progress both at home and abroad. The government has provided financial assistance for all service personnel who wish to obtain further education and training in the work of their choice. In anticipation of the return of nursing sisters wishing to take further studies, and in collaboration with the Matrons-in-Chief of the Armed Services, we have enquired of each nursing sister what she plans to do on demobilization. From these replies it is possible to estimate roughly the number of nursing sisters returning to former positions, the number wishing to study, and those planning to return immediately to nursing service. Thus, administrators of hospitals and university schools may better prepare for increased numbers of applicants for the different clinical services and specialties.

Also, the national committee is working on an over-all plan while the provinces work on their local plans. The work of the central committee aims to strengthen the provincial committees in

the various provincial programs being planned to meet specific local needs. We are pleased to give the names of the conveners of the provincial postwar planning committees in order that you may directly contact the province of your choice for special information at any time:

Alberta: Miss I. Johnson, Roval Alexandra Hospital, Edmonton. British Columbia: Miss Alice Wright, 1014 Vancouver Block, Vancouver. Manitoba: Miss Hazel Keeler, Dept. of Nursing, University of Manitoba, Winnipeg. New Brunswick: Miss Bessie Seaman, 29 Wellington Row, Saint John. Nova Scotia: Miss Jean Forbes, 314 Roy Bldg., Halifax. Ontario: Miss Edna Moore, Dept. of Health, Parliament Buildings, Toronto. Prince Edward Island: Miss Katharine Mac-Lennan, Provincial Sanatorium, Charlottetown. Quebec: Rev. Sister Lefebvre, Institut Marguerite d'Youville, 1185 St. Matthew St., Montreal. Saskatchewan: Miss Edith Amas, c/o National Selective Service Office, 2nd Avenue, Saskatoon.

We hope at an early date to have on this page a complete list of educational courses available in our Canadian hospitals and university schools.

More About UNRRA

Canadian murses responded splendidly to the request from UNRRA for nurses for difficult foreign assignments. To the list of those who have been appointed we add the following: D. Lanteigne, Anne Giesbrecht, L. Rutherford, Mary Greenwood, A. Hemmingson, B. Benedict, D. Grad, Irene Bloomer, Eleanor Wheeler, Helen Haley, Mildred Bernado, Rhea Kavanagh, Dorothy MacTier, Louise Sheffer and Blanche Lettner.

The Canadian Nurses Association is responsible to the Canadian public for providing nursing service at home both to civilians and to the wounded returning from the battlefield. Thus we must weigh carefully the effect of the withdrawal of any number of nurses for service elsewhere. The Association, therefore, has set a quota for nurses available for UNRRA service. The first small quota was rapidly filled to meet UNR RA's emergency need for general staff nurses for hospital work in the Middle East. A new quota of fifty nurses for all categories was set in November. The authorities at UNRRA headquarters in Washington have prepared a reserve of qualified personnel for immediate call when needed. Some eighteen Canadian nurses' names are now on this reserve

The general progress of UNRRA activities can be followed in the daily newspapers. We can only hope that the

delay in bringing succor to those so long oppressed will be very short.

To those interested in serving with UNRRA, application forms and details concerning qualifications, etc. may be obtained from the Executive Secretary of each provincial registered nurses association. In brief, the following conditions must be fulfilled:

Educational and professional qualifications: An academic degree, with graduate training in your specialty; at least two years supervisory experience in that specialty.

Most positions are for public health supervisors but a few hospital supervisors are still required.

Availability: The nurse is responsible for her replacement on staff, whether in hospital or public health nursing. The labour exit permit may be withheld until replacement is assured.

Physical fitness: The rigorous life anticipated for those going into the liberated countries requires vigorous good health. Exposure, privation, and isolation are promised to those who see this service!

Marion Lindeburgh
Convener
Committee on Postwar Planning

1944 Approved List of Hospitals

The American College of Surgeons announces that 3,152 hospitals in the United States and Canada are included in the 1944 Approved List. The list is published in the annual Approval Number of the College Bulletin issued December 31.

A total of 3,911 hospitals were included in the 1944 survey and the approved hospitals represent 80.6 per cent. The first annual survey in 1918 included 692 hospitals of 100 beds or over of which only 89 or 12.8 per cent merited approval. Hospitals of twenty-five beds and over are covered in the current surveys.

A total of 2,342 hospitals of 100 beds and

over were on the 1944 survey list, and 2,182 or 93.1 per cent were approved. A total of 1,119 hospitals of 50 to 99 bed capacity were under survey of which 789 or 70.3 per cent were approved. A total of 450 hospitals of twenty-five to forty-nine bed capacity were under survey of which 181 or 40.2 per cent were approved.

On December 31 of each year the ratings of hospitals under survey by the American College of Surgeons automatically terminate. The status of every hospital based upon all data collected from the current survey is reconsidered each year.

-American College of Surgeons.

STUDENT NURSES PAGE

Essentiality No. 1 - The Home

B. KING
Student Nurse

School of Nursing, Winnipeg General Hospital

It all began one Saturday after supper when the family had gathered in the living room. Mr. Smith sat in the easy chair, scanning the headlines of the daily newspaper. Mrs. Smith cupped her face in her hands and made mental notes - "Mauve is the new spring color — Ham and eggs in potato nests now that April is here" - this from the Women's Page. Mingled sounds of hero worship came from the floor where nine-year-old David and his baby brother Jerry were sprawled on the rug, deeply engrossed in the feats of their idol, Superman. Mary, a typical fourteen-year-old, was more interested in the dress Ginger Rogers wore in her latest picture, as she comfortably curled herself up on the chesterfield with an open copy of a magazine on her knee.

In the mind of each there was no thought of the near tragedy that was to come to them as it has come to so many Canadian families. Mr. Smith was well established in business and bought Victory Bonds regularly. The children had War Savings Certificates that were filled in religiously each week. Only Mrs. Smith felt that her contribution to the war effort left something to be desired. The newspaper answered her problem in brilliant advertising "Canada needs you — release one more man for active service." So it was that on the following Monday, Mrs. Smith, clad in overalls

and kerchief, punched the time clock in a nearby factory.

Necessary arrangements had been made. Mr. Smith had his lunch downtown as usual and came home for dinner in the evening. Mary and David took Jerry to a day nursery on their way to school in the morning and picked him up at 4 p.m. Mary prepared dinner for the family at 6.30 and her mother worked the evening shift once every week. Mary and David received extra allowance for their work and everything went smoothly — for a while.

David was a good boy. He had a normal boy's curiosity, love of excitement and adventure, and most of all, he, like the other boys in the neighborhood who had working mothers, needed companionship and a place to call "home." A gang had grown up among them and they used an old shack on an empty back lot for a clubhouse. At first it was just fun - they played baseball and horseshoes and went home at suppertime. But soon some of the boys began to "sleep out" under the soft summer night. Then of course they needed food and some of the luxuries of a home in their clubhouse. Canned goods, a lamp, a radio, cushions, cigarettes all these things were thieved from neighboring groceterias.

Young boyish spirits called for ex-

citement and adventure and this was achieved by tormenting two boys of foreign blood who lived "across the tracks." The boys felt quite patriotic and justified in hurling threats and insults at them. Bitter scrambles would ensue before policemen sent them scattering. Then one day as the two boys were fleeing from the invading gang, David picked up a stone and hurled it at their retreating figures. It caught the German boy on the back of the head and he fell to the ground. Believing him dead and very badly frightened David turned and ran. He hid that night in a dark grain bin and later crawled into the boxcar of an outgoing freight.

Mary felt quite grown-up with her new found responsibility. It was fun at first to have the entire care of the house - getting dinner, doing dishes, and caring for baby Jerry. But even an enthusiastic fourteen-year-old soon tires of these things and Mary was no exception. She began to use just a little make-up and tried to effect hair stylings like her favorite film actresses. She and lanet, the girl from across the street, began to go out evenings. At first they went to the corner drug store for a soda, then back to do their homework. Then they began to stay out later and strolled arm in arm through the streets. As they passed the barbershop and poolhall, young men gathered there whistled at them, occasionally some of them followed the girls home. That older men should notice her was very flattering to Mary's awakening ego. Help was needed on curb service at the little roadhouse just outside town so Saturday night found Mary, dainty, attractive, and cute and innocent in a frilly white apron, taking and filling orders. Not that night, but several nights later two very charming young men in uniform offered to give her a lift home and Mary accepted.

It was a thoroughly frightened mother who arrived home from work that Saturday night to find Jerry in a heap beside his crib and a sobbing neighbor's girl bending over him. A frantic examination found him unharmed and bit by bit Mrs. Smith got the story from the little girl. But where was Mary? She should be back from the roadhouse. And David — where was he? Her husband's footsteps sounded on the walk and together they hurried to the police station, after safely depositing Jerry in the care of a neighbor.

It took the police force very little time to pick up a frightened, weeping Mary who was walking alone into town. David was found in the next town and with kindness and the assurance that he had not killed, but stunned the German boy, he was persuaded to come home. His offence was brought before the town judge who fortunately was an understanding man. David was not punished — he had learned his lesson, so had Mary, and best of all, so had Mr. and Mrs. Smith.

This narrative is only one of many occurring everyday in this country of ours. It illustrates the greatest factor in causing and the greatest means of preventing juvenile delinquency, namely war and the home. A country at war is one in which its young people are suddenly faced with adult situations. High school girls find that their carefree boy companions have overnight become men who have a task before them that may cost them their lives. Emotions run rampant and the feeling that "this time may be the last time," leads young people to a social behaviour that under other circumstances would be abhorent to

Though war is one of the greatest factors, it is not the only one. Indifference of parents to their own moral life and the teaching of their children; poverty of families leading to petty thieving and later major crimes; lack of group organizations for young people which provide a healthy outlet for their normal spirits—these are additional factors.

The children of today are the men

and women of tomorrow. Delinquency has no place in the set-up for the new world that everyone dreams, prays and hopes for. Then it is a challenge to parents, schoolteachers, judges, policemen—to every citizen, to see that our children are clean and strong in mind and body. Such is their birthright.

Book Reviews

Mental Hygiene, by D. B. Klein, Professor of Psychology, University of Texas. 498 pages. Published by Henry Holt & Co. Inc., New York. Canadian agents: Clarke, Irwin & Co. Ltd., 480 University Ave., Toronto 2. 1944. Price \$2.80 & 15 per cent.

Reviewed by Selena Henderson, R.N., Mental Hygiene Section, Division of Child Hygiene of the City of Montreal. Presented primarily as a text-book for students of psychiatry and psychology this book attempts also to meet the needs of the general reader. The author views his subject from a rather different angle and deserves credit for not being afraid of showing that psychology and moral principle are not incompatible as theoretically presented works on the subject, as is generally believed.

The subject matter of the book is divided into two broad spheres of activity: (a) Mental Diseases, discussed in parts 2 and 3; (b) Mental Health, parts 1 and 4. Either can be read independently of the other.

(a) Part 2, The Nature of Mental Disease, classifies mental diseases and gives an elementary, working knowledge of each of the disorders listed. Part 3, preventing Mental Disease, supplies the reader with the present status of knowledge concerning their prevention. The author summarizes these sections by the significant remark: "Emotional security ... seems to be the pivot of mental health. The roots of this security are embedded within the life of home and family".

(b) Part 1, The Nature and Scope of Mental Hygiene, is an introductory chapter to part 4, Promoting Mental Health. This section provides the most profitable reading of the entire book. The author himself advises "if one can read only a part of the book to read this portion".

Public health nurses, social workers, teachers and parents will find it especially helpful. There are excellent chapters deaing with the home and the school. Here also the author deals with such topics as a healthy philosophy of life, the cultivation of varied and stimulating interests, the hazards of undisciplined wishful daydreaming, and the importance of emotional security within the home. In it he includes references to efficient techniques of repression, the desirability of having friends and getting along with people, and has much to say about coping with the annoyances and frustrations of everyday living.

The material of the entire book is presented in an easy-to-read style suited as well to the lay reader as to the student of psychiatry or psychology. Technical terms are explained or elaborated by means of simple, and usually concrete examples. Finally, a glossary of the technical vocabulary has been appended to facilitate understanding by the general reader. After reading it, workers of some experience in the field of applied psychology and psychopathology will not feel, as they have in closing other books on the question, that textbooks and theory on the one hand and actual case material on the other are so hard to reconcile one to the other. An excellent book for a study group.

Chest Surgery for Nurses, by J. Leigh Collins, B.Sc., M.D., F.R.C.S., in collaboration with L. E. Mabbit, S.R.N. 128 pages. Published by Baillière, Tindall and Cox, London, Eng. Canadian agents: The Macmillan Company of Canada, St. Martin's House, Toronto 2. 1944. Price \$2.25. The collaboration of a chest surgeon and a nurse with wide experience in the care of surgical chest disease has resulted in the production of an exceedingly informative book. In addition to very careful and lucid descriptions of all of the disease conditions which may affect the chest, there are nearly one hundred sketches which are of great value in clarifying every detail both of structure and of treatment.

The first section outlines the anatomy of all the parts included in this part of the body, their physiology and mechanics. Section two begins with an account of the general clinical principles involved. The role of the nurse in this type of care is stressed. "The importance of good nursing in the treatment of surgical chest conditions is well recognized to be of relatively greater significance

than it is in most other branches of nursing . . . So many individually small details in treatment can make or mar a patient's chance that it is essential that the chest surgical nurse should be of the first calibre with a considerable fundamental knowledge of her subject". The rest of the chapters deal with the various pathological conditions and their treatment, dividing the whole area and studying possible injuries and diseases in the chest wall, the pleura, the lung, the mediastinum, the diaphragm and the vessels. A series of interesting x-ray pictures is appended as a supplement. Line drawings interpret the deviations from the normal chest which adds to the interest.

This book would be very useful in nursing libraries for both student and graduate nurses.

The Nurses' Lending Library of the R.N.A.P.Q.

One of the simplest ways of keeping up with the latest developments in nursing is by reading some of the really fascinating books published especially for us. This hobby may become expensive, however, and we are not, on the whole, particularly prone to amass books. Moreover many nurses in this scattered province of Quebec cannot browse in the shop of a bookseller who carries this line of books, unless they happen to live in Montreal.

The Executive committee of the Public Health Section of this province, therefore took upon itself the task of gathering up a lending library. They asked many nurses in all fields of work what books they themselves wanted and pooled these suggestions. About thirty books were chosen covering topics such as medical nursing, obstetrics, child welfare, school hygiene, the control of tuberculosis, mental hygiene, nutrition, industrial hygiene, and a few biographies and popular style books appertaining to the medical world.

A circular letter was sent to approximately 300 public health nurses, including those working in industry, with an accompanying list of the books. All nurses in good standing have access to the library. It is housed in the provincial secretary's office

and books are mailed on receipt of a postcard, lending time being one month. The town nurses sometimes come and choose a book, the library being open during office hours. The funds came from the federal government grant and the requests for some types of books have been so great that a second copy has had to be bought.

The library is a little over six months old and although it started off with a very good list of readers, lately it has been literally shelved. Let us all read more and keep on learning!

Mrs. Jessie Harding Flora Moroney.

Fire-resistant Paints

Two fire-resistant paints for ship use have come out of the war so far. One of them, for use mainly on steel, will discolour but will not burn when brought into contact with flame. The second goes a step further and actually acts as a fire extinguisher, by giving off a fire-smothering vapor when exposed to flames. It is used largely for the protection of the woodwork of a ship.

A New Year Episode

During an eighty-five mile per hour gale of wind and rain, we occupants of the nurses residence of the Colchester County Hospital, Truro, were startled about 4.30 a.m. New Year's night by a loud crash — accompanied by sounds similar to the crackling of fire. Bare feet struck the floor, doors opened, and pyjama-clad figures appeared from everywhere frantically wondering what we should take in case of fire. However, we soon realized the crash was the roof, part of which had sailed away through the air, leaving a hole for the rain to descend upon

our unprotected heads! Pots, pans and mops arrived on the scene, also the janitor whose appearance made some of the more timid souls hurry to their rooms for bathrobes while others, forgetting their attire, remained at their posts. Eventually excitement quieted and we scurried back to bed to catch those few precious winks before reporting on duty. Later on in the day a new roof was put on the building and more peaceful sleep is hoped for on windy nights. At least the New Year brought a new roof to the residence!

-RUTH BENVIE

Institute in Manitoba

The School of Nursing Education of the University of Manitoba is sponsoring an Institute for Head Nurses and Supervisors on Ward Teaching and Supervision during the first week in May. Miss Margene O. Faddis, Professor of Medical Nursing, Frances Payne Bolton School of Nursing, Western Reserve University, has kindly con-

sented to conduct this Institute. Miss Faddis is well known to Canadian nurses through her contributions to the field of nursing literature.

For further information write to the Director of Nursing Education, University of Manitoba, Winnipeg.

Letters from Overseas

News from the South-west Pacific

Would like to begin by describing our departure from our former station but fear the censor would not approve so will tell you about that after the war.

We landed in a heavy tropical storm and travelled by jeep from place of landing to the camp. You cannot possibly imagine the "highway"! Trees had fallen across the road and bridges had been washed away but the jeep just kept on going. Those cars certainly take a beating. It is a fact that they will jump over logs and drive through water so deep that the radiator is covered.

We were all very dirty and mud-splashed at the end of the trip which was no short ride. Of course we all wear slacks, safari jackets, high boots and leggings and it is a sensible costume for this part of the world, not only because of the mud and dirt but to protect us from the various insects with which the place is infested. We have orders to apply repellents to our clothing and any exposed parts of the body, such as face, hands and neck. This is not too pleasant as the repellent is rather sticky and has an odour but it does give one a certain sense of security.

When our men came up here there was nothing but jungle and kuni grass. They set up in a kuni grass area after burning down the grass. By setting up, I mean that they built a hospital in the jungle. The wards have tin roofs and cement floors. The only



MARCH, 1945

other protection is a form of screen which runs the length of the structure and about half way up to the roof. These are called open wards. Some of the administration huts are native and do look quite picturesque. The officers and men live in tents without floors and I do not understand how they manage to keep themselves clean or dry. The nurses are living in barracks of a rather crude architecture but we feel like plutocrats and have named our barracks after some of the New York hotels. I am staying at the "Biltmore"; we are thirteen to a "house". Our quarters are well screened. The showers are in a somewhat translucent structure but even that seems to be a minor matter. None of the buildings are rain-proof. It rains at some time during each twenty-four hours and rains very hard. A few minutes later the sun is out in full strength again and we are dripping in perspiration constantly. Quite recently a laundry has been installed where we may send our heavy clothing and bed linen. This is a great help as it is impossible to get clothes dry unless one is constantly on the watch for the daily storm. The mud is quite a factor. During and immediately after a storm we literally plough about and think nothing of "mud to the ankles". About half an hour later all is dry again, thanks to that hot sun.

The Chapel is the prettiest of the buildings. Father Joe, our chaplain, is a hard worker and his work here is a great credit to him.

With the exception of the natives and one Australian mission there has been no habitation here except for the Japs who have been chased away and now the Aussies and Americans have the place to themselves.

The matter of amusement or entertainment seemed a remote possibility when we first arrived but within forty-eight hours we received an invitation to an Aussie tea, I might say high tea, and had a delightful time. Had a ride in a landing barge and felt as though we were in the middle of things. They gave us very excellent refreshments including chicken sandwiches and very fine coffee. A few nights later a few of us were invited by a group of Navy men we had met at the tea to go on a picnic. This was a great experience. They drove an American jeep through the jungle until a clearing was reached and then spread raincoats on the mud and opened various bags and produced numerous treats. The girls are

still black and blue from the extraordinary rough ride and I could show a couple of beautiful bruises myself. Some of you may remember my ability to bruise.

We are not encouraged to go off the post more than two or three times a week and there is good reason for such a recommendation. In this climate one needs more rest and sleep than in a more temperate climate to say nothing of the possibility of being marooned during a storm. It is not unusual to find yourself stuck on a reef; it may be sometime before something comes along to drag you off again.

One of the most difficult jobs up here is that of dietitian. Have not yet seen any fresh meat. We have bully beef in every conceivable manner. The canned fruit saves the day as it takes the rather unpleasant though faint taste of bully beef away. Our menu three times daily is made up of the above plus bread and sometimes fresh butter. The coffee, I almost forgot to mention, is very good. We have electricity and telephones in wards, tents, and quarters and that is a blessing. Of course the power is generated on the premises.

You will conclude that our camp covers quite a large area. Set in the centre of the camp is a bit of a village. We have a post-office, barber shop (which affords no privacy — I cut my room-mate's hair), tailor shop and post exchange. The post exchange sells soap, razor blades, and tooth-paste and we each have a trunk-load of such supplies.

When we dress up we wear the costume described above plus lipstick and nail polish. We all take atabrine as do all personnel in malarious areas and have a rather deep yellowish tinge to our skin and that particular tinge is not too becoming with the khaki clothing. Toilet water is a precious possession. Within the next couple of months I expect to get leave. We get fifteen days plus travel time. That will give me plenty of time to visit the cities I have in mind. It will be quite a trip from here. Thank goodness I am a good sailor and do not get plane sick. Before leaving America I purchased an atlas and find it very interesting to follow our movements on the map. Just a few more little jaunts and I will have been around the world.

For the honour and glory of R.V.H. I am glad to be able to report that I was promoted to the rank of First Lieutenant. They may make a real soldier of me yet. Expect the



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MARCH, 1945

R.V.H. girls are having a great experience in Europe by this time. Hope that they have had no casualties. Five of our girls have been evacuated—three with a skin disease known as Jungle Rot and two with nervous disturbances. There is considerable scrub typhus and much malaria in these parts. We have lost some of our men who had typhus but have had very few cases of malaria within our group. Of course we all try to develop the art of dodging mosquitoes.

-1st Lieut. Kathleen N. King

News from Belgium

We are now in Belgium and find a great difference not only in the country but in the people. The country is very much like that of the prairie provinces with very little or no roll. Trees are much scarcer than in France and rivers and canals more plentiful. The canals are made into things of beauty, not, like ours at home, strictly utilitarian. There are lovely flower plots and picturesque groups of trees all along them. The bridges, those left, are rustic, in cement, and harmonize beautifully with the surrounding countryside where there are still a few yachts to be seen. The people are most expressive and friendly—it is very difficult to ignore their interest.

We are extremely well situated at the moment, being in permanent buildings and much more comfortable than in Normandy mud. Still we have a nostalgia for the life under canvas — it was fun, albeit uncomfortable at times. Our quarters, about ten minutes from the hospital, are in homes and apartments and are quite comfortable although they will be more so if we get our windows replaced. More likely than not a new location will be found for us before that is done. You know the army style.

I wish you could see the people here. They are beautifully groomed and clothed in well-kept, pre-war garments, which have been remade and remade till, even now, one would almost think they had stepped out of the pages of Vogue. I certainly wish I had their ability. I'd always be well-dressed. The stores, although plentifully supplied with luxuries, are pitifully lacking in the necessities of life. There is perfume a-plenty but little meat and bread.

Our mess here is like something out of a movie, and no one who had not seen it could believe that it could exist in real life. The walls are in a beautiful maroon brocade

while the ceilings are in panelled oak and the woodwork in a peculiar grayish-green, which is in perfect colour harmony. The music room, off the mess hall, is a picturesque place. The walls are in cream with multicoloured frescoes on them while the ceiling is something that only an artist could have planned. The central portion is a high cupola of stained glass and is surrounded by some of the most intricately carved woodwork I have ever seen. The single ceiling light is shaded by an Indian shade of beautifully wrought iron; it is such fine work that it looks almost like filigree. Most of the furniture in this room is in Indian ebony inlaid with mother-of-pearl, something one might dream of but never see. The floor, too, is a work of art; it must have taken months to assemble. Most of the wood looks like a light oak. Only one thing-I'd hate to be under any of the chandeliers during a raid; they would be a little heavy on the head.

-LIEUT. WINONAH LINDSAY

H. M. C. S. "Niobe"

We have a small hospital here and the work is pleasant, although it could scarcely be called hectic. I almost felt guilty speaking to the Army nurses who work such long hours. I met several whom I knew when I was on leave in London. Also we spent two lovely days at "Digswell", that heavenly spot in Herts, for Canadian sisters. I would have liked to have spent all my leave there except that more exciting things were afoot in London.

My only brother who is in the Air Force and who had been missing since May turned up safe and well in London two days before I began my leave! So I think you can imagine the happy reunion we had there. He gained ten pounds while living with a Belgian family during his sojourn on the continent and is now headed for home for a month's leave.

-RUTH GOUINLOCK

News from Italy

Enjoying the work tremendously. My happiest moments are those spent on the wards. The boys are so very fine and appreciate any little thing we may do for them. I think we are very fortunate being able to see so much of this country. So many places which I used to dream about but never thought I'd see. Rome, with so many fascinating things,

its priceless paintings and treasures, absolutely untouched by war.

I just spent three days in Florence but did very little sight-seeing there. One interesting point is the Ponte Vecchio built in 996 and the only one of the six bridges crossing the Arno which is left standing. It is very unique in that it has stores and homes built right in the bridge. The stores had lots of nice gifts and I did some Christmas shopping.

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-LIEUT. AILEEN TULLOCH

R.C.A.F. Nursing Service

The Director of Medical Services (Air) announces the following promotions and changes which have taken place recently in the R.C.A.F. hospitals overseas and in Canada:

N/S M. E. Armstrong (Ottawa Civic Hospital) was awarded the A.R.R.C. in the New Year's Honour List for outstanding duty while on duty at an R.C.A.F. Station in Newfoundland.

N/S H. M. Brown (Misericordia Hospital, Edmonton) was awarded King's Commendation for valuable service. N/S Brown is at present serving overseas.

The following promotions have been approved recently:

A/Principal Matron (Squadron Leader) M. T. Montgomery, A.R.R.C. (Wellesley Hospital, Toronto) is Principal Matron of the R.C.A.F. Nursing Sisters serving over-

A/Matron (Fl.-Lieut.) F. M. Oakes, A.R.R.C. (Kitchener-Waterloo Hospital), following duty overseas, is now Matron at R.C.A.F. Station Hospital, Trenton, Ont.



To keep hands smooth—Hand Cream

Scrubbing up leaves hands and arms red and sore — Cutex Hand Cream whitens, soothes and smooths them! Not sticky. Big full-ounce jar for only 39 \(! \)



HAND CREAM

A/Matron (Fl.-Lieut.) H. M. MacLennan (Toronto General Hospital) is Matron at a R.C.A.F. hospital in Newfoundland.

A/Matron (Fl.-Lieut.) E. V. Crosson (Winnipeg General Hospital) is Matron at the R.C.A.F. Detachment Deer Lodge Hospital in Winnipeg.

A/Matron (Fl.-Lieut.) J. F. Young (To-

ronto General Hospital) and A/Matron (Fl.-Lieut.) M. E. Jackson, A.R.R.C. (Brandon General Hospital), now serving overseas, have recently received their promotions.

A/Matron (Fl.-Lieut.) E. I. Jarrott (Toronto Western Hospital) is the assistant to Principal Matron J. E. C. Porteous, R.C. A.F. Nursing Service at Air Force Headquarters in Ottawa.

Royal Canadian Naval Nursing Service

The following promotions became effective on January 1, 1945:

Matron F. M. Roach (St. Michael's Hospital, Toronto) to Principal Matron, R. C. N. Hospitals, Newfoundland.

N/S E. W. Ledingham (Vancouver General Hospital) to Matron, R.C.N. Hospital, H.M.C.S. Cornwallis.

Matron S. M. Beck (Victoria General Hospital, Halifax) was awarded the A.R.

R.C. in the King's New Year's Honours List. Matron Beck has recently returned to Canada having served overseas for the past two and a half years.

Matron O. Wilson (Royal Jubilee Hospital, Victoria) has been appointed overseas as Matron, H.M.C.S. Niobe.

N/S C. A. J. Evans (Victoria Hospital, London) to A/Matron, R.C.N. Hospital, H.M.C.S. St. Hyacinthe.

R.C.A.M.C. Nursing Service

In His Majesty's New Year's Honour List awards were conferred on the following: R.R.C.: A/Major (P/M) Anna M. Allen (Winnipeg General Hospital); Major (P/M) Rose L. King (Victoria General Hospital, Halifax); A/Major (P/M) Janet MacKay (Royal Victorial Hospital, Montreal); A/Major (P/M) Helen Shanks (Royal Victoria Hospital, Montreal); Capt. (Matron) Hilda M. Boutilier (Sydney City Hospital, N. S.)

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Janet Wallace (Toronto General Hospital); Lieut. (N/S) Margaret Zeggil (Homewood Sanitarium, Guelph); Lieut. (N/S) Patricia Collins (Toronto General Hospital); Lieut. (N/S) Helen V. Sinclair (Belgrave Hospital, London, England).

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The following are recent changes which have taken place in the public health nursing field staff:

Mrs. R. D. McAllister (Vancouver General Hospital and University of B. C. public health nursing course) has been appointed public health nurse in Rossland.

Mrs. Doris Brentzen (Hazelton Hospital, affiliation with Royal Columbian Hospital, New Westminster) has been appointed to a position in the Cowichan Health District, Duncan.

Mrs. Annie L. Owens (Royal Jubilee Hospital), following an intensive course in epidemiological work, has been appointed as a specialized worker in New Westminster and the Fraser Valley.

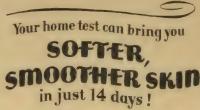
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Mrs. Elizabeth Martin, Vernon school nurse, has retired after many faithful and appreciated years of service.

Mrs. Isabel Foster, recently appointed consultant in public health nursing, has resigned to make her home in the United States.





Compare your complexion with your shoulders. You'll find your shoulders look 5 or more years younger. Why? Because shoulder pores are kept clean by your regular Palmolive Soap baths—and so, able to breathe freely. But face pores, clogged with dirt and make-up, can't breathe freely and soon your complexion loses its flexible softness and ages before its time. That needn't happen to your complexion. Palmolive offers an easy way to keep it radiantly lovely.

Wash your face 3 times a day with Palmolive, and each time, with a face-doth massage Palmolive's lather into your skin—for an extra 60-0 seconds! This easy Palmolive Massage stimulates the cir-

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Alberta Department of Public Health

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Margaret Burton, B.Sc., Drumheller, resigned to go with the Blood Donors Travelling Clinic in the south of the Province.

Hazel Wilson has been transferred from Lindale to take over the Drumheller health district, and Wilma McCordick is the new appointment to Lindale.

Mrs. Cathie Somerville has arrived from Sioux Lookout, Ontario, to take over the district of Mrs. Glen LaBerge (Isabel Cruikshank).

Margaret Dunbar returned to Alberta after several years in the East, and after relieving at Tangent for Miss Dufresne who took the advanced course in obstetrics at the University of Alberta, she settled at Bow Island.

Dorothy Kaufman, formerly of Bow Island, has been transferred to Kinuso in order to use her skill in obstetrics.

Alice Hitz has gone to Plamondon while Elizabeth Standing is on leave of absence in Edmonton.

Sheila MacKay of Calgary was appointed to the district at Hemaruka.

Mrs. R. Taylor (Mary Willis), Worsley, is carrying on in her district until a new appointment can be made.

Florence Harrison has returned from sick leave and is now stationed at Blueberry Mountain.

Mrs. Audrey Cavil was appointed to the district at Lomond following the resignation of Naomi Pow who returned to hospital work.

Dorothy Colgan is now stationed at Maloy while Mrs. Cole has returned to her district at Alder Flats.

The Health Unit staffs have had some recent changes as follows: Maxine Bow resigned from Clover Bar to go to the V.O.N. Montreal. Ruth McClure left Clover Bar to join the Toronto City Health Dept. staff. Marian Murray, Holden health unit, is on leave of absence serving as travelling public health instructor for the A.A.R.N. Isabelle Macdonald has been appointed to the Two Hills health unit. Chris Anderson joined the Clover Bar health unit. Mrs. Montie Croft has been appointed to the Legal health unit.

M.L.I.C. Nursing Service

Laura Bardier (St. Charles Hospital, St. Hyacinthe, P. Q. and University of Montreal public health nursing course) was recently transferred from Quebec City to take charge of the Metropolitan Nursing Service in Thetford Mines, P. Q.

Olive Carrier (St. Mary's Hospital School of Nursing, Montreal, and University of Montreal public health nursing course) was recently transferred form Montreal to take charge of the Metropolitan Nursing Service in Joliette, P. Q.

NOTES NEWS

ALBERTA

EDMONTON:

At the recent annual meeting of the Royal Alexandra Hospital Alumnae Association the following officers were elected for the ensuing year: honourary president, M. S. Fraser; president, V. Chapman; vice-presidents, Mrs. N. Richardson, A. Lord; recorddenis, Mrs. N. Renneds; corresponding secretary, Mrs. D. Ferrier; corresponding secretary, M. A. Kennedy; treasurer, B. Long; committee conveners: program, Mrs. J. F. Thompson; visiting, M. Moore; social L. Watkins: extra executive, Mrs. R. Umbach, M. Griffith, I. Johnson.

Following the business meeting Jean Reilly, Opal King, and Janet Cook, student nurses, entertained with music and songs.



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other protection is a form of screen which runs the length of the structure and about half way up to the roof. These are called open wards. Some of the administration huts are native and do look quite picturesque. The officers and men live in tents without floors and I do not understand how they manage to keep themselves clean or dry. The nurses are living in barracks of a rather crude architecture but we feel like plutocrats and have named our barracks after some of the New York hotels. I am staying at the "Biltmore"; we are thirteen to a "house". Our quarters are well screened. The showers are in a somewhat translucent structure but even that seems to be a minor matter. None of the buildings are rain-proof. It rains at some time during each twenty-four hours and rains very hard. A few minutes later the sun is out in full strength again and we are dripping in perspiration constantly. Quite recently a laundry has been installed where we may send our heavy clothing and bed linen. This is a great help as it is impossible to get clothes dry unless one is constantly on the watch for the daily storm. The mud is quite a factor. During and immediately after a storm we literally plough about and think nothing of "mud to the ankles". About half an hour later all is dry again thanks to that hot sun.

The Chapel is the prettiest of the buildings. Father Joe, our chaplain, is a hard worker and his work here is a great credit to him.

With the exception of the natives and one Australian mission there has been no habitation here except for the Japs who have been chased away and now the Aussies and Americans have the place to themselves.

The matter of amusement or entertainment seemed a remote possibility when we first arrived but within forty-eight hours we received an invitation to an Aussie tea, I might say high tea, and had a delightful time. Had a ride in a landing barge and felt as though we were in the middle of things. They gave us very excellent refreshments including chicken sandwiches and very fine coffee. A few nights later a few of us were invited by a group of Navy men we had met at the tea to go on a picnic. This was a great experience. They drove an American jeep through the jungle until a clearing was reached and then spread raincoats on the mud and opened various bags and produced numerous treats. The girls are still black and blue from the extraordinary rough ride and I could show a couple of beautiful bruises myself. Some of you may remember my ability to bruise.

We are not encouraged to go off the post more than two or three times a week and there is good reason for such a recommendation. In this climate one needs more rest and sleep than in a more temperate climate to say nothing of the possibility of being marooned during a storm. It is not unusual to find yourself stuck on a reef; it may be sometime before something comes along to drag you off again.

One of the most difficult jobs up here is that of dietitian. Have not yet seen any fresh meat. We have bully beef in every conceivable manner. The canned fruit saves the day as it takes the rather unpleasant though faint taste of bully beef away. Our menu three times daily is made up of the above plus bread and sometimes fresh butter. The coffee, I almost forgot to mention, is very good. We have electricity and telephones in wards, tents, and quarters and that is a blessing. Of course the power is generated on the premises.

You will conclude that our camp covers quite a large area. Set in the centre of the camp is a bit of a village. We have a post-office, barber shop (which affords no privacy — I cut my room-mate's hair), tailor shop and post exchange. The post exchange sells soap, razor blades, and tooth-paste and we each have a trunk-load of such supplies.

When we dress up we wear the costume described above plus lipstick and nail polish. We all take atabrine as do all personnel in malarious areas and have a rather deep yellowish tinge to our skin and that particular tinge is not too becoming with the khaki clothing. Toilet water is a precious possession. Within the next couple of months I expect to get leave. We get fifteen days plus travel time. That will give me plenty of time to visit the cities I have in mind. It will be quite a trip from here. Thank goodness I am a good sailor and do not get plane sick. Before leaving America I purchased an atlas and find it very interesting to follow our movements on the map. Just a few more little jaunts and I will have been around the world.

For the honour and glory of R.V.H. I am glad to be able to report that I was promoted to the rank of First Lieutenant. They may make a real soldier of me yet. Expect the



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— as a means of encouraging fluid intake and providing easily utilizable carbohydrates.

Horlick's — prepared with water or with milk — presents a palatable food-drink that finds ready acceptance with the sick child. This opens the door to providing necessary fluid intake, because Horlick's can be given as often as desired.

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MARCH, 1945

R.V.H. girls are having a great experience in Europe by this time. Hope that they have had no casualties. Five of our girls have been evacuated—three with a skin disease known as Jungle Rot and two with nervous disturbances. There is considerable scrub typhus and much malaria in these parts. We have lost some of our men who had typhus but have had very few cases of malaria within our group. Of course we all try to develop the art of dodging mosquitoes.

-1st Lieut. Kathleen N. King

News from Belgium

We are now in Belgium and find a great difference not only in the country but in the people. The country is very much like that of the prairie provinces with very little or no roll. Trees are much scarcer than in France and rivers and canals more plentiful. The canals are made into things of beauty, not, like ours at home, strictly utilitarian. There are lovely flower plots and picturesque groups of trees all along them. The bridges those left, are rustic, in cement, and harmonize beautifully with the surrounding countryside where there are still a few yachts to be seen. The people are most expressive and friendly-it is very difficult to ignore their interest.

We are extremely well situated at the moment, being in permanent buildings and much more comfortable than in Normandy mud. Still we have a nostalgia for the life under canvas — it was fun, albeit uncomfortable at times. Our quarters, about ten minutes from the hospital, are in homes and apartments and are quite comfortable although they will be more so if we get our windows replaced. More likely than not a new location will be found for us before that is done. You know the army style.

I wish you could see the people here. They are beautifully groomed and clothed in well-kept, pre-war garments, which have been remade and remade till, even now, one would almost think they had stepped out of the pages of Vogue. I certainly wish I had their ability. I'd always be well-dressed. The stores, although plentifully supplied with luxuries, are pitifully lacking in the necessities of life. There is perfume a-plenty but little meat and bread.

Our mess here is like something out of a movie, and no one who had not seen it could believe that it could exist in real life. The walls are in a beautiful maroon brocade

while the ceilings are in panelled oak and the woodwork in a peculiar grayish-green, which is in perfect colour harmony. The music room, off the mess hall, is a picturesque place. The walls are in cream with multicoloured frescoes on them while the ceiling is something that only an artist could have planned. The central portion is a high cupola of stained glass and is surrounded by some of the most intricately carved woodwork I have ever seen. The single ceiling light is shaded by an Indian shade of beautifully wrought iron; it is such fine work that it looks almost like filigree. Most of the furniture in this room is in Indian ebony inlaid with mother-of-pearl, something one might dream of but never see. The floor, too, is a work of art; it must have taken months to assemble. Most of the wood looks like a light oak. Only one thing-I'd hate to be under any of the chandeliers during a raid; they would be a little heavy on the head.

-LIEUT. WINONAH LINDSAY

H. M. C. S. "Niobe"

We have a small hospital here and the work is pleasant, although it could scarcely be called hectic. I almost felt guilty speaking to the Army nurses who work such long hours. I met several whom I knew when I was on leave in London. Also we spent two lovely days at "Digswell", that heavenly spot in Herts, for Canadian sisters. I would have liked to have spent all my leave there except that more exciting things were afoot in London.

My only brother who is in the Air Force and who had been missing since May turned up safe and well in London two days before I began my leave! So I think you can imagine the happy reunion we had there. He gained ten pounds while living with a Belgian family during his sojourn on the continent and is now headed for home for a month's leave.

-RUTH GOUINLOCK

News from Italy

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Laura Bardier (St. Charles Hospital, St. Hyacinthe, P. O. and University of Montreal public health nursing course) was recently transferred from Quebec City to take charge of the Metropolitan Nursing Service in Thetford Mines, P. Q.

Olive Carrier (St. Mary's Hospital School of Nursing, Montreal, and University of Montreal public health nursing course) was recently transferred form Montreal to take charge of the Metropolitan Nursing Service in Joliette, P. Q.

NEWS NOTES

ALBERTA

EDMONTON:

At the recent annual meeting of the Royal Alexandra Hospital Alumnae Association the following officers were elected for the ensuing year: honourary president, M. S. Fraser; president, V. Chapman; vice-presidents, Mrs. N. Richardson, A. Lord; recording secretary, Mrs. D. Ferrier; corresponding secretary, M. A. Kennedy; treasurer, B. Long; committee conveners: program, Mrs. J. F. Thompson; visiting, M. Moore; social L. Watkins; extra executive, Mrs. R. Umbach, M. Griffith, I. Johnson.

Following the business meeting Jean Reilly, Opal King, and Janet Cook, student nurses, entertained with music and songs.

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> APRIL 1 9 4 5

THE

CANADIAN NURSE



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Canadian Army Photo

See page \$48







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APRIL, 1945

Registered at Ottawa, Canada, as second class matter. Editor and Business Manager: MARGARET E. KERR, M.A., R.N., 522 Medical Arts Bldg., Montreal 25, P.Q.

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APRIL, 1945 247

Reader's Guide

The whole problem of family allowances, as they are to be applied in Canada, has been receiving very considerable attention in the past few months. On the one hand there will be praise for the prescience of the Federal Government in thus anticipating the new forms of social legislation which would prove such a boon to all of our citizens. Health insurance which had been discussed as the probable opening phase was relegated to a later time for a variety of reasons and "baby bonuses" substituted. From many quarters has come marked disapproval of this change of direction. Dr. George F. Davidson, who discusses the plan for family allowances, has had a very broad experience in social welfare work. Today. as Deputy Minister of Welfare in the Department of National Health and Welfare, his interpretation of the workings of the plan will help us to understand the situation.

Dr. Alton Goldbloom is chairman of the Department of Pediatrics at McGill University and acting Physician-in-Chief, Children's Memorial Hospital, Montreal.

It is stimulating to get the opinion of such a busy executive as R. M. P. Hamilton, president, General Engineering Co. (Canada) Ltd., Toronto, as to what the management in industry expects from the development of health services within the plant.

Blanche McPhedran is assistant principal of the Toronto Western Hospital School for Nurses. Margaret McNeill is a private duty nurse in Charlottetown, P.E.I. Madeline McCulla is acting director of the School of Nursing, University of Alberta, Edmonton. Sheila MacKay is provincial public health nurse at Hemaruka, Alta. Certainly the "Macs" have taken over the Section Pages this month!

Our cover shows a reproduction of an oil painting by Lieut. L. P. Harris, of Nursing Sister F. M. Copeman, R.C. A,M.C. The original painting is on display at the National Gallery in Ottawa. The courage and devotion of all of our nursing sisters is reflected in this portrait. They are giving of their best. Can we do less?

Invest in the Best!



Canadian Army Overseas Photo

In a Canadian tent hospital somewhere in Italy.



The radio sound man is one of the mysterious "they" in the common expression of wonderment, "What will 'they' think of next?" The ominous rumble of thunder, so terrifying to millions of radio listeners, he creates by deftly striking and shaking a huge sheet of tin plate. From other contrivances born of his ingenuity, the crackle of flames, the splash of rain, the drumming of horses' hoofs are simulated with startling fidelity. Practically every sound from the flutter of the wings of a butterfly to the clamor and din of a busy factory comes within the range of his ingenuity.

The medical research worker is inge-

nious, too, but in quite a different manner. For although his accomplishments may seem as magical, with him there are no imitations, no pretense, no theater. In parasitized rye, he has found ergot. From the mold Penicillium notatum, he has developed the powerful penicillin. His work is based on scientific fact, and the fruits of his labors must be subjected to extensive and severe clinical trial, in which the studies of a year may be lost in an hour. In addition to ingenuity of the highest order, the medical research worker must possess unlimited patience, tireless energy, and courage unexcelled. His contribution to medical practice and the public health is immeasurable.

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to Buy Thatoy BouldNATIONAL WAR FINANCE COMMITTEE

APRIL, 1945

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A MONTHLY JOUR NAL FOR THE NURSES OF CANADA PUBLISHED BY THE CANADIAN NURSES ASSOCOIATION

VOLUME FORTY-ONE

NUMBER FOUR

APRIL 1945

Helping our Nursing Sisters

In a recent letter from one of our nursing sisters, now serving in Europe, these very significant sentences occur: "Our greatest problem is that of reading material. If there are any more sisters who go to you before coming over, would you please tell them to subscribe to several of their favorite magazines".

There is in this message a real challenge to alumnae associations, local registered nurses associations, and to individual nurses in all parts of Canada. What are we doing to help our colleagues on the battle-fronts refresh their minds in their off duty hours? We have all contributed to book funds for the soldiers but how much have we spent on reading matter for our own colleagues? Perhaps we have taken it for granted that they are subscribing to their own magazines and don't need our help. Some of them are, no doubt, but how long does it take us to read one magazine? If we want something new to read, we can step down to the nearest drugstore and pick up what we wish to read
— in English, not in Flemish or French
or Italian, etc.

What can we do? The post office authorities refuse to accept parcels of magazines or newspapers going to our nursing sisters. The only way they can be sent is through a subscription directly to the publisher. Books, however, may be sent through the mails and there is an infinite variety of books available in pocket-size editions ranging all the way from cook-books to the most grisly "whodunits". If by any remote chance you do not know the addresses of any individual nursing sisters, the copies could be sent in care of the matrons of the various units.

You will be glad to know that complimentary copies of *The Canadian Nurse* are sent each month to every one of the units overseas. The nurses are beginning to be concerned about "the problem of finding work for ourselves after the war is over". This correspondent con-

tinues: "There is a great deal of discussion going on but most people over here are a little doubtful about the future". The Journal is publicizing the plans and activities of the Postwar Planning Committee of the Canadian Nurses Association. For their help and guidance, see that individual copies of the Journal

reach the graduates from your School of Nursing or the girls from your town.

The plans we may evolve are long overdue—but don't let us waste time in recriminations! Let us get a wealth of reading material flowing to our nursing sisters.

—M.E.K.

Good Luck to the New Graduates

Within the next few weeks nurses in all parts of Canada will be completing their university post-graduate courses and beginning their work as public health nurses, as instructors or supervisors in schools of nursing, or as administrators in hospitals. There will be very mixed feelings, for the year which is concluding, while it has meant strenuous study and concentration has also given an opportunity for the welding of many new friendships and inspiring discussions. As the last examination papers are handed in, the last essays and assignments completed, a concerted sigh of relief will rise as some, nay most, of the students will solemnly vow that those were the very last examinations they would ever write!

The months immediately preceding the end of the term also contain many moments of thought and consultation regarding the next step—the job. Quite a few of the students will be returning to positions from which they were released for study. But for the majority, this post-graduate training has opened a new field, and these will be weighing the relative values of this position as compared to service with that agency. Since opportunities are plentiful, applications will be filed with a variety of organizations or hospitals. Of course only one position can be accepted. Here, the

operation of the golden rule — do as you would be done by — can ensure continued cordial relationships if the nurse will take the trouble to notify other agencies where her application is pending when she has accepted a position. It may appear a very small matter to her but it may cause considerable disruption when half a dozen or more nurses neglect this courtesy.

Quite a large proportion of the incipient graduates from university courses have been the recipients of bursaries or scholarships. With the acceptance of this award last Fall, these nurses obligated themselves to make a definite return in the form of service. On these, then, will rest the ethical responsibility of fulfilling the terms of their contract. It is indeed a tribute to the integrity of the nurses that of the hundreds who have received some form of financial assistance, a number so small as to appear negligible have failed to live up to their obligations. It is a curious reflection on human nature that we hear of these defaulters but pass by the overwhelming majority who have not failed.

To all of these new workers the Journal extends heartiest good wishes for success in their chosen field. Remember, there is plenty of room on top for those who scale the ladder.

---M.E.K.

Family Allowances—A Children's Charter for Canada

GEORGE F. DAVIDSON, Ph.D.

Twice in the past twenty-five years the searchlights of science and war have been turned on the standards of living in the western world. They have been found seriously wanting for great numbers of people in even the most favoured countries, as the startling number of medical rejections for military service testify.

Nations have come to realize that without a healthy and vigorous people there can be no prosperity. On an increasing scale they are devising and instituting measures of economic and social betterment to combat what Sir William Beveridge has called the wicked giants of Idleness, Want, Disease, Ignorance and Squalor. The devices are various but interdependent. Decent housing conditions and greater educational opportunities will help to defeat Squalor and Ignorance. The remedy for Idleness lies in full employment, that is, in maintaining and expanding production, ,on the one hand; on the other, in maintaining a steady flow of consumer purchasing power - regular spending on food, clothing and other necessities of life. Health services for everyone will combat disease, but in themselves cannot develop a healthy people unless Want is disposed of; unless a minimum standard of health and decency can be maintained at all times.

In Canada a forthright attack has been made upon Want by the Family Allowances Act which will place \$250,-000,000 in Canadian homes each year. Beginning in July, cash allowances will be paid monthly from general tax revenues towards the maintenance, care and upbringing of all children under sixteen living in a family unit. There are thus two questions to answer: Why have family allowances been chosen as the spearhead for the post-war development of

economic and social security? What benefits will accrue to justify this redistribution of income?

In any structure of social security family allowances occupy a key position because of the multiple purpose they serve. The heart of the family allowance scheme lies, perhaps, in its attack on individual poverty to the extent that this grows out of factors in the wage system. Wages bear no relation to the size of the wage-earner's family. They are paid roughly on the basis of his training, skill, and the type of work performed. A married person obviously cannot rear and educate healthy children on a wage sufficient for only one person. The present necessity to do just that has forced many families below the poverty line. It must be clearly understood, however, that family allowances are not tied to the wage system, and do not limit collective bargaining. They are not a substitute for fair wages. Family allowances lessen the inevitable inequalities that cannot be met by wage adjustments. They assist parents in proportion to their family responsibilities. Family allowances are, in short, a recognition by the state that children are a national asset, and that, in the national self-interest, they must be given the protection of decent and healthful living conditions.

Furthermore, the allowances promote the prosperity of the country as a whole by placing increased purchasing powers in the hands of families most in need of the basic commodities of food, clothing and shelter. Expenditures on consumers' goods make up a very large

APRIL, 1945

^{1 &}quot;The first cause of hunger and malnutrition is poverty. It is useless to produce more food unless men and nations provide the markets to absorb it". United Nations Conference on Food and Agriculture.

proportion of our national income. Food alone is the most important single trade commodity and constitutes one-third of the cost of living. Two hundred and fifty million dollars represent a good deal in the way of food, clothing and services on the domestic market. Its regular circulation, year in and year out, will stimulate the demand for goods, and contribute to the creation and maintenance of a high level of employment.

These practical social and economic returns on money invested in family allowances are recognized by many countries of widely differing political and economic structure. Some form of family allowances has been introduced in over thirty countries, including the sister dominions, New Zealand and Australia. The British government has promised to establish them immediately after the war as a part of their post-war program of reconstruction and social security.

The principle of family allowances is not new in Canada. It has been recognized in dependents' allowances in the armed services, and, earlier, in mothers' allowances, relief payments and workmen's compensation. Income tax reductions for dependent children have been allowed to persons within the taxpaying bracket. At the present time less than half the 3,500,000 children of Canada are receiving benefit from these reductions. The Act extends benefits similar to those enjoyed by persons within the income tax category to two additional groups: those whose incomes are so low they receive less than the full income tax reduction, and those who are under the present taxable level of \$1200 a year.

A considerable section of the wage-earning population falls within these two groups. According to the census figures for 1941 the incomes of 57.1 per cent of the wage-earning population outside agriculture came below \$1200 a year. One-third of the total urban heads of families earned less than \$999; another third earned \$1000 to \$1499. It might be well to recall here that, in 1939, the Welfare Council of Toronto

estimated \$28.35 weekly, or \$1474.20₂ a year, to be the minimum required in the Toronto area to maintain a family of five in health and self-respect, and then only with the most careful planning, If this figure is taken as a rough yard-stick, it is obvious that family allowances will be a godsend to these two groups.

Nurses, of course, are well aware of the importance of nutrition in relation to the needs of growing children. Like social workers, they have seen their skilled services go down to defeat before the finality of income so limited it could not be stretched to cover the barest minimum of nourishing food. An examination of family income, with and without the addition of family allowances, shows the effect the allowances can have on family standards of diet.

Under the Act, the allowances vary in amount with the age of the children in the family. They increase as the children grow older and the expense of maintenance increases, ranging from a minimum of \$5 a month for a child under six, to \$8 for a child thirteen and over. Six to nine-year-olds get \$6 a month and ten to twelve-year-olds, \$7 a month. On the assumption that some of the clothing and equipment purchased for older children can be used for the younger, the allowance is decreased for children after the fourth. These gradations add enormously to the administrative complications but they are an attempt to ensure equitable treatment for all.

A couple with three children age 2, 11 and 13 years, whom we will call the Jones family, would thus receive a family allowance of \$20 a month or \$240 a year. This amount would bring their annual income of, say, \$950 up to \$1190, or to put it another way, increase the family income from \$190

² In terms of 1944 prices, the revised Report estimates that \$35.85 (\$1864.20 a year) is needed to cover the same budget.

per person per year to \$238 per person. This may mean the difference between actual want and at least a minimum standard of existence. For example, a study of income and expenditure of urban wage-earners' families in Canada, 1937-38, indicated that families with annual incomes under \$199 per person showed deficiency in all nutritive requirements. Thus with the addition of the family allowance, the Jones family would be brought out of this category into the \$200-299 a year grouping. According to the findings of this study, they will now have a sufficient supply of calories but will still be deficient in other res-

Dietary studies have established the fact that food consumption per person falls as the family increases in size. This is particularly true of the protective foods such as butter, milk, eggs, cheese and vegetables, which tend to be replaced by bread and potatoes. Family allowances should do much to stay this trend in Canada, even without the very desirable reinforcement of increased public education on nutrition.

There is, as yet, little information in Canada on agriculture income in relation to family size. It would be dangerous to assume that farm homes are less in need of supplementary diets than their city counterparts. The types of homegrown produce available on the farm depend a good deal on climatic area as well as on dietetic knowledge. Bread and potatoes too often occupy a disproportionate place on the farm menu. The import of fresh fruit and vegetables to the local market from milder areas is necessary at certain seasons on the prairies and in the northern districts of other provinces.

An increasing knowledge of nutrition and more accurate vital and social statistics have shown a lot of unswept corners in our national housekeeping and revealed some grim facts about the health and welfare of large sections of the population. The effect of dietary deficiency on the health, vitality and rate of growth of children, and on their ability to learn, has been amply demonstrated, here and abroad. Even so, we have taken only the first faltering steps in studying nutrition in relation to the total budget of different income levels of the population. One direct effect of family allowances may be the stimulation of community groups to conduct surveys similar to that of the Toronto Welfare Council, in urban centres, small towns and representative rural areas.

More food, and more wholesome food, are by no means the only needs of the Jones family. They may be sacrificing other vital wants to an adequate menu. In particular, medical and dental requirements are apt to be neglected, or postponed until a critical stage is reached, and the cost to the family and the community is considerably higher than if preventive care or early treatment had been given. In point of fact, the average parent cannot afford to purchase adequate health services for his family. The health insurance proposals under consideration for the past two years recognize the limitations of the family budget in this respect and would provide free health and medical care for all children under 16. Until health insurance comes into effect, family allowances will help to pay for medical attention, visiting nursing and other services of the kind.

Furthermore, shoes and warm clothing are an ever-present expense where there are children. Fuel may be short, another room may be needed, or a proper mattress for straight growth. An endless variety of needs come under the simple heading of "food, clothing and shelter". The only general terms in which they can be expressed is money. And the only persons who know these needs of particular children are the parents. Administrative experience in dispensing relief, mothers' allowances and, during the war, dependents' allowances indicates misuse of funds in a very small percentage of cases. Furthermore, provision is made in the Act to take the allowance away from parents who are

incapable or unwilling to spend it for the betterment of their families, and to place it under the control of some other person or agency.

It is true that family allowances alone will not bring social security. But they are a firm foundation stone. They are one more step forward in the history of child protection. It seems a far cry to the era of Dickens when schools, workhouses, prisons, and factories bore a dismal similarity, and health and nu-

trition were words of an as yet unknown language. The general level of living has risen immeasurably since then. Nevertheless, progress since those stark days has been in great and little steps as groups here and there awakened to duties and obligations, and made the community increasingly aware of its larger responsibilities. Each step forward has been an innovation and a struggle in progress. Family allowances is one of those steps.

Management and the Promotion of Industrial Health Services

R. M. P. HAMILTON

"Management" is a very general term, and it should be stated that "good management" regard their responsibilities as an obligation-in-trust, requiring them to co-ordinate the bona fide needs of their source of financial support, whether this source be the shareholders of a commercial company, or taxpayers of a country, with their chief means of producing — which is their employee-staff.

Management, from an impersonal viewpoint, is made up of innumerable components, the important ones being, in so far as they affect industrial health service, three main influences or forces, viz:

1. The natural interest of the normal employer in the well-being of his employees.

2. The growing realization of even absentee directors that it pays dividends to keep employees healthy.

3. Applied public opinion, which is perhaps an inadequate but still a practical way of expressing the benefits, authority, and leadership derived from, and exerted by, such bodies as the public

departments of health, and the employees themselves.

An industrial health service is a key industrial relation factor linking management with employees. Mutual confidence is the lubricant which makes this link between management and staff work well, or badly, depending on the degree of confidence present. Medical people will realize that "mutual confidence" is a two-way affair.

Functional forces affecting medical services: Even though management's medical knowledge may be limited to an idea as to when to use "aspirin", the chances are they can understand the problems of the medical services. If you want their help you should keep them posted and, objectively speaking, in your confidence. The strongest force for improving medical service comes from the average management's own interest in the welfare of their employees. Wanting to put the case in simple, practical language, as a parallel to carrying out the desires of a medical service, we went to our safety officer, and director of research, from whom we got this fundamental answer to the question from a functional standpoint:

Our analyses show the components of an industrial health service to be: Interest by the employer in employee well-being; business recognition that industrial health service pays a commercial return; public opinion provided by the department of health. The question is, how can these be resolved into one force? The answer is, these forces, like other industrial relation problems, combine in the overall objective — "Prevention of Waste."

PREVENTION OF WASTE

You wonder why we took so long to build up this philosophy of "Prevention of Waste". The reason is illustrated in the two main principles which guide every activity in successful industrial health service:

1. The first principle is indicated by the assistance obtained in defining the basic objectives of a health service. The first source of information, advice, or guidance is the department of public health. The second source is the industrial doctor immediately concerned with the industry in question. If there is no such doctor, one should be contacted who is acceptable to the department of public health, preferably recommended by them. The third source of assistance in carrying out the medical service is represented by the engineering department of the industry, which must be called in on such matters as ventilation, illumination, sanitary facilities, safety facilities, etc. (Later we will touch on other departments which are definite factors in facilitating a medical service, particularly in the large industries, but for the moment the engineering group will serve to illustrate them all.)

In industrial health work, problems will occur which cannot, or shoud not be solved alone. A successful health worker will recognize the necessity of calling in complementary talent, and the good industrial health worker will be proud of the frequency with which he taps other assistance rather than attempting to work miracles alone, (for example, consider toxic dust elimination, lighting, etc.).

2. The second principle is illustrated by the simple philosophy of the phrase "Prevention of Waste". It seems to me that the main difference between a laborer and a professional person is that the latter usually follows an understandable philosophy. To guide one's self steadily amongst the intricacies of any job worth doing, one should be able to fit one's objectives into some simple overriding philosophy, such as the "Prevention of Waste". When you think of it, personnel work, safety work, medical work, nutrition service, all come under the same heading as does the business man's reason for watching his costs. This watchfulness on the part of management can be made an asset to a medical service if both are governed by the principle of "Prevention of Waste".

Co-operation with Allied Departments

Although, so far, we have only referred to an engineering department as an essential aid to health service, it is obvious to anyone who considers the question that the best industrial health services in the world will be wasteful of time and money if they do not have adequate support from the other agencies of management. Included in direct agencies of management, along with the medical and engineering departments, are safety, personnel, production, inspection, research, sales, accounting, purchasing, etc.

The medical service will, or should, rank equal to any of these other departments, but usually has no jurisdiction over them. For this it is dependent upon

the support of top management. Top management is not going to put up with a daily series of complaints or requests for support from any department, even such an important one as the medical service. Rather than depend on the sympathetic support of top management, which would be lost if too often required in detail, it is, therefore, up to the medical service to cultivate the respect and the interested regard of the other departments, without which a medical service will fail.

In discussing what amounts to the working co-operation between departments, we have not yet mentioned the plant Union, or the ordinary employee. In mentioning them now, it is unnecessary, one hopes, to stress the fundamental necessity of acquiring and maintaining their respect. If this employee-respect is not maintained it is obvious that the employees will not use the medical service and the medical service is, therefore, useless to the management or anyone else.

"Co-operation" is an overworked word, but if really put into practice it could cure all our industrial ills, whether physical or economic. The troubles occur when one of the parties who should co-operate expects the other fellow to do all the co-operating, and declines to meet him half-way because to do so would not suit his own ideas of the moment.

Functionally speaking, all organizations have the same problems. In the broad sense, the industry with a dozen employees, whose "medical department" is somebody who had first aid training as a child, has the same fundamental problems as the 25,000-man industry. The differences between the big and little industry are two: Big industry tends to suffer from the difficulties of maintaining personal contact, and no good human relationships can be maintained for long on a purely mechanical or statistical basis. Small industry, however, cannot afford the specialized facilities which the same percentage expenditure of time or money provides for big industry. These two factors more or less balance each other out, and one doubts very much if the industrial health problems in a big industry are any bigger or more easily soluble than those of a small industry.

Working with the nutritionists of a large industry to improve the meals in their cafeteria, a health service may find itself temporarily stopped by the comptroller. He will insist on the purchase of low-grade meat in order to reduce an apparent but immediate loss to the company through more costly food. It may be just as difficult, and take just as much applied patience and diplomacy on the part of the large company medical service, to obtain relief from the accounting dictum, as would obtain in the case of a fifty-man industry where the parttime industrial nurse may need to enlist aid to stop the local "greasy-spoon" from serving countless weird concoctions.

It is suggested, therefore, that there is little use considering one's own job unusually difficult. A large part of any professional success depends upon the ability to master the circumstances and personal equations which tend to retard professional progress.

The problem boils down to selling your knowledge or your ideas. The first essential in salesmanship is to create confidence. It should be remembered that confidence is a mutual affair, and to obtain the management's confidence, it is necessary to give them the confidence of the medical or other department desiring this close relationship.

INDUSTRIAL MEDICAL "SELLING" HAS FOUR PHASES

1. "Selling" the management boils down to demonstrating that the employee and, therefore, the company, get adequate return for money spent on employee health. The general method we, as management, use to convince our superiors is to show that our medical service costs under one half of one per

cent of our otherwise fixed costs. This is in an industry with explosive hazard and some toxic conditions in addition to ordinary accident problems. The directors, knowing that it costs us between twenty-five and fifty dollars to hire an employee, and between fifty and one hundred dollars to train him (depending on the times and work requirements) appreciate the value received from medical expenditures. Social security taxes are mounting by leaps and bounds and every business man know the first line of defence is "medical service".

2. "Selling" the other departments on the value of your service's requirements to them is sometimes slow. However, absenteeism costs the employer more than the employee by 50 per cent. Also 80 per cent of the visits to our medical department are due to non-occupational troubles and supervision of health is the key to prevention of this waste.

3. "Selling" the worker on the value of medical service to them is usually easy, (e.g., lost time due to illness is largely preventable—it averages fifteen times that due to accident and amounts to nine days per year per worker).

4. "Selling" the public on the value—to them—is usually done through the company. In the last hundred years industrial workers increased from 12 per cent to 29 per cent while agricultural workers decreased from 72 per cent to 21 per cent of the people at work. The increasing importance of good industrial health to the State is, therefore, obvious.

Management Problems of Interest to the Medical Service

Costs come high in any management docket, since no industry can operate long at a loss. Industry has, generally speaking, become accustomed to a cost of up to one dollar per month per employee for industrial medical service. Employees average ten to twelve calls per year at the medical department of an industrial service.

In meeting the management's need for controlling costs, the medical service will always find three things: Once they have earned a reputation for cost-consciousness, the management will increase the departmental freedom; most health objectives can be obtained at relatively low dollar cost, provided sufficient thought is spent on the proper means of obtaining the objective; once the worker is "sold" on health consciousness from a practical medical viewpoint, the worker contribution to industrial health will grow quickly by such obvious means as: (a) personal attention to sanitation, food, rest, etc.; (b) obedience to medical suggestions such as attention to specific diets, transfer from harmful occupations, etc.; (c) willingness to spend their own money on medical services such as hospitalization, which industry cannot supply.

The handling of labor turnover, absenteeism, training, alertness, job evaluation and many similar management problems can all be aided by a good industrial health service. The method of handling the management's problems from the viewpoint of industrial health is sound planning by the medical department. Policies and procedures should be studied if available in writing, and sought out and clarified if not.

Elements of Industrial Medical Service from Management Viewpoint

Assume that we are in an averagesized industry with the usual problems including a reasonably health-conscious management of normal intelligence:

(a) The medical service will be expected by the management to provide: (1) Pre-employment examination for guidance to the employer in worker placement, in accordance with plant Policy and Procedure. (2) First aid care and compensation data. (3) Prevention of spread of communicable disease. (4) Preparation of rudimentary statistics as to lost time due to compensable acci-

dents as distinct from non-occupational illness. (5) Advice to management of any important plant causes of occupational illness and means for controlling them. (6) Advice to employees who become ill while at work — up to the point of seeing their family physician. (7) Supervision of sanitary conditions

throughout the plant.

(b) Additional accomplishments, possible with an aggressive medical service co-operating with other departments under a sympathetic management, include: (1) Advice as to workers' clothing and working conditions from the health standpoint; for example, aid in getting necessary eyeglasses, corrective shoes, and provision of adequate light on work. (2) Education of the workers in co-operation with nutritionists towards better feeding both at work and at home. Many poor workers are poor workers because they are underfed or badly fed. (3) Co-operation with public health advancement measures such as tuberculosis picture surveys. (4) Co-operation with the safety department in eliminating industrial accidents and through periodic medical examinations, eliminating sick people from work. Most accidents occur to tired or sick people. (5) Co-operation with production and engineering departments in eliminating harmful working conditions; for example, much of our dermatitis problem was eliminated by provisions of adequate dust collection and lighting. (6) Co-operation with wage-study departments in evaluating jobs, such as analyzing and comparing physical or nervous stresses on various jobs, (7) Co-operation with personnel and operating departments in getting and keeping healthy and satisfied employees. Quiet advice to these departments enables them to understand, place properly, and look after employees having special conditions of health or nervous strain. (8) Acquire practically valuable statistics on a variety of medical problems being studied by public health officials. (9) Carry out specific occupational and industrial medical researches. (10) Visit absent or known-to-be-sick employees for two purposes, viz: (a) to advise the company as to probable length of absence; (b) to advise the employee as to how to get necessary medical care from his personal physician, hospital, or elsewhere if such care is needed.

(c) Ten Commandments: or the things which management expects medical service to avoid: (1) Any act or practice unfair to any employee. (2) Participation in the inevitable plant politics. (3) Activities in union politics. (4) Sign of favoritism to individual patients. (5) Sign of disinterestedness in an employee's real or fancied illness. (6) Participation in disciplinary measures. When necessary, these must be taken by the proper department, which is never the medical department. (7) Lack of frankness in reporting objectively on any case of sickness or accident to the management, whose duty it is to keep confidence. (8) Sign of taking sides in either a company-employee or an inter-departmental dispute. (9) Lack of cooperation with public health officials. (10) Personal act which would detract from the employees' friendly respect for the company nurse or doctor.

Preview

With maternal mortality still a serious public health problem in Canada, the discussion of puerperal care and some of the complications which may occur becomes of immediate interest and importance. Dr. William J. Stevens has shown us how vital good nursing care is in the prevention of untoward complications.

An important factor in preparation for the delivery is the adequacy of the prenatal care that is given. Kate McIlraith has outlined the nurse's role in this for us, stressing her value as a teacher. To round out the picture, Frieda Allum describes the physical set-up and classes held in a prenatal clinic.

A Twenty-five Year Retrospect of Infant Feeding

ALTON GOLDBLOOM, M.D.

The apparently simple present-day methods of feeding infants stand out in sharp contrast to the methods practised and the beliefs held a generation or so ago. The reasons why we do or do not do certain things, why we do or do not give certain foods, have changed materially together with our practices. It is by no means uninteresting, nor is it without some measure of indulgent amusement, to look back over the road which we have travelled this past quarter century to see where we have got to and where we have come from; perhaps, too, to try to see ahead a bit to where we are going.

A generation ago, infant feeding was regarded as a high and complex art and by no means a simple one. It required a year or two of study and practice to learn well. One studied pediatrics particularly with a view to learning infant feeding. It was the key to a successful pediatric practice. I remember a distinguished pediatrist of the United States who had at the top of his letterhead the words "Practice Limited to Infant Feeding"; and he was a busy man. If you were a young and ambitious doctor and wanted to be a pediatrist, you chose the school of infant feeding which you thought was the most advanced, and you went there to learn the method. You went to Boston to learn "percentage feeding", while another went somewhere else to learn "caloric feeding". It was the method of feeding that was most important. What was behind the method was the desire on the part of all pediatrists of the day to try so to modify cow's milk by dilution and by the addition of sugar, etc., as to make it resemble human milk in its composition; the reason being, of course, that if you could produce a reasonable facsimile of human milk, you would then have no trouble in feeding infants. All the efforts of those interested in the subject were directed towards producing an imitation of human milk. Today our aim is to provide an infant with adequate food on which it can thrive, without regard to the manner in which it may differ from human milk.

The appalling mortality of artificially fed infants in those days, and the manifest failure of all the divergent methods of feeding, made it necessary to have always on hand a fairly large supply of human milk in hospital feeding and, in homes where they could be afforded, wet-nurses for those infants who were very ill. New York and other large cities had wet-nurse directories, some maintained privately, like employment agencies, others by public charity organizations. Hospitals for children often kept as many as half-a-dozen wet-nurses, their infants admitted as "feeding cases" to the "feeding ward" as it was called; the wet-nurses were assigned to do light work and to pump or strip their breasts several times a day. This was thought to be better than the method of supplying district nurses to collect breast-milk from mothers who lived at home, nursed their babies, and sold the excess to the hospital at from four to six cents an ounce. The method was highly developed in Boston where at the Floating Hospital the "milk maids" would meet the boat when it docked in the late afternoon, each heavily-laden with the day's takings; bottles upon bottles of milk gathered from dozens of nursing mothers in the district. The trouble was that these mothers, who were selling their precious milk at a price for the sake of saving the lives of poor sick children in the hospital, were not above adulterating this milk, either by the oldfashioned method of adding water to

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it, or by the simple expedient of mixing it with cow's milk. These frauds were fortunately detectable by simple methods. The wet-nurse in the hospital had no reason for practising such frauds, because she had her keep, light work and a home for her infant; moreover, she stripped or pumped her breasts under supervision. But she was a nuisance; she felt indispensable, as indeed she often was, and acted accordingly. Yet it was a great comfort to the attending physician to know that there were five or six quarts of breast-milk always on ice for use for our more difficult feeding problems. Indeed, many an infant was tided over a most critical period with human milk, when other milk would have failed.

The feeding of all infants in the hospital was directed by the head physician of the ward. No one else dared prescribe or change a formula. The interne merely observed with rapt attention and interest how this clever and omniscient man went about on his rounds changing the formulas according to his judgment. His judgment was based upon the weight, on the presence and nature of vomiting, and on the character of the stools; the last being by far the most important. A distinguished lady pediatrist, then an interne, used to call them "stool rounds". One might call them fecal fascination, or coprophyllic fetishism, or divination by stool. The professor purported to know, by examining the stool of each baby, what was wrong with him and how the food should be changed. And this was a ritual! The stool of each child had to be saved for rounds. They were done up neatly in brown paper folders and "filed" alphabetically. It was the duty of the junior interne to have charge at rounds right after breakfast - of the basin containing the stool filing system. Of course, he could not stand too close to the professor and his followers; he was obliged to stand at a distance. When the professor approached the bed of an infant, the resident would call out the infant's name; the junior interne would look through his file, get out the desired folder, open it, approach the professor and from his breast pocket respectfully withdraw and present a wooden tongue depressor. The professor would then examine the stool, far more carefully than he ever examined a baby. He would comment on it, smear it back and forth with the spatula, smell it, and often deliver a short lecture on its characteristics. How we would marvel when the professor guessed, from the appearance of the stool, what food the baby was getting. "Dextri-Maltose" he would say. Some one would look at the chart, and Dextri-Maltose it was! "Protein milk" he would say - again he was right. A great man indeed! Then would come the great moment when the formula was changed: "Add 1/4 per cent of fat, take out 1/2 per cent of sugar, and split the proteins". The orders were carefully noted, and it was the duty of the junior interne to figure out the formula from a prescription that went something like this: "2 — 6.50 — $1.50 - 30 \times 7$ " which meant that a mixture was to be ordered that would contain 2 per cent of fat, 6.5 per cent of sugar (which was always lactose unless otherwise specified) and 1.5 per cent of protein. There was to be 30 oz. of this, and it was to be divided into seven feedings. The sugar was always lactose, because that was the sugar present in human milk. We often smiled indulgently when we found a sick infant whose mother or whose doctor had been foolish enough to give him granulated sugar - no wonder the child was ill. The idea about sugar changed when the price of lactose went so high during the first world war that most people could not afford it. It was the late Dr. Howland, then professor of pediatrics at Johns Hopkins, who showed that cane sugar did just as well as any other sugar and was of course much cheaper.

Splitting the proteins was an under-

taking in these days, about as arduous as splitting an atom. It meant that the whey proteins and curd proteins were to be so arranged in the formula as to be of somewhat the same composition as they are found in human milk. When the order "split proteins" was given, it usually specified what percentage of casein and of lactalbumin it was to contain. The poor junior had to indulge in mathematical calisthenics in order to arrive at the proper mixture of cream or top milk and whey which would give the desired proportions. Until you caught on you wished Einstein were at your side to help you - eventually it became child's play. Protein was ordered "split" usually because the stool showed a bean curd, which represented a bit of milk curd that had escaped the action of the digestive juices, perhaps on account of its size. Yet its presence meant a fault in the infant's digestion and called for this drastic change.

Bean curd was also the reason for the almost universal use of barley-water for diluting the milk. Any cereal gruel mixed with milk prevented the formation of large tough curds; but barley, "patent barley", was the choice. It was a bit of heresy to use anything else, and "patent barley" sold for close to a dollar a pound, as did oven-browned ordinary wheat flour which, under a trade name, threatened to swamp the popularity of "patent barley". It resulted, therefore, in a great saving in money when, at the Babies Hospital in New York, the late and great Dr. L. Emmett Holt used ordinary wheat flour, either browned or natural, for making gruels for formulas, Dr. Holt was a scientific man, and he ordered the change only after he had demonstrated to the satisfaction of everyone that the gruel made from flour was as well digested as barley flour, and that it was equally effective in preventing bean curds from appearing in the stools. Boiled milk which also prevented bean curds was not as good for babies as raw

milk, so that was not a way out of the difficulty.

Controversies raged over whether one should give high-fat or low-fat feedings. After all, if we were to follow the composition of human milk, we must feed 3 to 4 per cent of fat, but unfortunately this was rarely tolerated by many infants already debilitated by malnutrition. You were either a high-fat feeder or a lowfat feeder, and you either hated your opponent heartily or you had a sympathetic tolerance toward your poor misguided friend. There were feuds, and hot ones too, over whether one should use top-milk or whole milk in making up a formula. Top-milk formulas were difficult to understand; whey and curd formulas (split protein) were even more complicated. Neither were eminently successful, particularly with sick infants, and their popularity was short-lived.

There were a number of flagrant contradictions which were regularly practised in those days and which we, of the then younger generation, were quick to observe and query. The infant was unable to tolerate more than a certain percentage of fat, say 2, 3 or 4 per cent, depending upon whether you were a high-fat feeder or a lowfat feeder; but you always gave the baby three teaspoonfuls of cod liver oil, and often a teaspoonful of olive oil if he was constipated; yet this half ounce of pure 100 per cent fat never seemed to bother either the high-fat feeder or the low-fat feeder - this was medicine and didn't count. Another contradiction was the following: While all milk had to be diluted and modified for infants, sour milk could be given without dilution. In fact the Dutch method, which was said to have been a very old folkmethod, consisted of sour milk to which, of all things, cane sugar was added, and it worked. This benefit was supposed to be due to the lactic-acid bacilli of the sour milk. In some vague way they made the food digestible by altering the intestinal bacteria. Whatever the reason,

whole lactic-acid milk with added sugar was a refuge when the standard methods and all other methods failed.

Milk had to be given raw. Not even pasteurization was good enough for formulas. Although Jacoby in the latter part of the last century was the first to advocate boiled milk for infants, and experience had many times demonstrated the greater tolerance of infants for boiled milk, the reasons for insisting on raw milk were that by boiling the milk the vitamins were destroyed and the enzymes were killed. What enzymes no one has ever yet learned, or of what importance they were to the infant; yet the enzymes were destroyed and milk must be given raw. This led to the development of "certified milk" - that is, milk from tested herds and produced under such conditions that the bacterial count was so low that it was safe to give to infants. This milk was twenty-five cents a quart, so that the benefits were for the rich only. The poor had to get along as best they could with pasteurized milk.

When I began to practise I was several times called to see children suffering from abdominal tuberculosis. The story was invariably the same; the child had been doing poorly — the doctor advised milk fresh from the cow. The people moved to the suburbs, and bought a cow whose milk was given fresh to the infant. Often such cows were tuberfulous, and the unfortunate infants became infected. Such experiences were sufficient to convince a young pediatrist of the value of sterile milk for the feeding of infants.

The amount which the baby was allowed to have at a feeding was carefully controlled by the doctor. The rule was that a child might not have more at a feeding in ounces than his age in months plus one. Thus if he was three months old, he was allowed four ounces at a feeding and no more. The poor infant often was unaware of this rule, so when he cried he had colic. If you gave

him more, there was danger of dilating his stomach. Why, infants on the breast who often gorged themselves with seven or eight ounces at a feeding at six or eight weeks didn't die horrible deaths, was quite beyond comprehension! Then the x-ray came along to show that the infant, whatever the capacity of his stomach, passed liquid food along into the duodenum rather quickly. Thus the rule was abandoned.

Our knowledge of vitamins in the second decade of this century was vague and limited. The one best understood was vitamin C, which was called "water-soluble C". All children received orange juice from a fairly early age, and knowledge of other sources of the vitamin was increasing. Tomato juice was found to be effective, but you could obtain this only by draining off the juice from a tin of canned tomatoes. Many mothers objected to this practice, because they abhorred the idea of giving their precious infants anything out of a can. It required some years to eradicate this prejudice.

In my early days of practice in Montreal, the late Dr. A. D. Blackader, who was always extremely generous to young men trained in pediatrics, sent me to see a child who was not thriving. The problem was not a difficult one, and was readily adjusted. The child was not ill, but was having a rather hard time with a formula that contained a lot of cream. I prescribed a simple formula of milk, sugar, and water, on which the child did quite well. I had ordered an ounce of orange juice to be given each morning. In a few days the mother complained that the infant did not tolerate the orange juice. I asked her to drain off the juice from a tin of tomatoes and give the child about two ounces of this each day. The poor mother was horrified at the idea of giving her baby anything out of a can, but my success in solving the feeding problem made it easy to convince her that this practice was both safe and beneficial. She

reported to me in a few days that the infant was doing nicely and that the tomato juice was being well tolerated.

For several months thereafter I was obliged to defend myself against the attacks of dowagers who had "never heard of such a thing". The story of myself and the tin of tomatoes kept coming back to me in many garbled forms. The final version of these apocrypha went something as follows: A baby was very ill and all the doctors had given it up. Nothing more could be done for it. Then up spoke one of the doctors and said "There is a young baby doctor in Montreal recently arrived from New York. Perhaps you might try him". I was accordingly called. I entered the house took one look at the dying baby and cried "Open a tin of tomatoes. Quick!" The tin of tomatoes was opened, the juice was given to the baby and the baby recovered!

Cod liver oil was given to prevent and cure rickets, but one was never sure whether it was something in the fish liver oil, or just any oil, which had the beneficial effect. Many schools held the view that any oil would do provided it contained phosphorus. In one hospital the clinic patients received as cod liver oil, a bottle of cotton seed oil to which was added a drop of oil of phosphorus. It was about in 1920 that it became to be fairly generally accepted that there was something in cod liver oil that many other oils did not possess, that had an effect in the prevention and cure of rickets. There soon followed the discovery of the effect of irradiation on rickets, then of the possibility of irradiating ergosterol; and finally the relationship between fish oils, irradiated substances, sunlight, etc., to the prevention and cure of rickets.

It gradually became evident that for an infant to do well, its food must be sterile, because many of its ills were due to bacterial diseases caused by raw milk. Boiled milk for infants had been advocated in the middle of the last century

by Abraham Jacoby, in his time the leading authority on pediatrics in North America; but his views on this matter were never adopted in his lifetime. At the time of his death the controversy was still raging between the advocates of raw certified, "grade A" pasteurized, and boiled milk. The late Dr. Howland settled this question without great difficulty. The practice in his clinic was to give the necessary amount of food as boiled milk and cane sugar. It worked much better than raw milk formulas, and that was that. One of his pupils, the late W. McKim Marriott, was a man of great brilliance and resourcefulness. It was he who popularized the use of corn syrup as a cheap and useful sugar for the infant's formula. It was he, too, who was largely responsible for the wide use of evaporated milk. Evaporated milk with two parts of water and an ounce of corn syrup for every twenty ounces of total mixture, acidified with about a teaspoonful of lactic acid, made, he taught, an ideal food mixture for an infant, and did not require "changing of the formula". The lactic acid was added because he felt that part of the infant's digestive problems were due to the fact that cow's milk had the property of using up a good deal of the acid secretions of the stomach, so that when the acid was neutralized by the milk there was not enough secreted to permit normal digestion.

The addition of an acid to milk was a new idea. It was based upon the knowledge that infants could tolerate undiluted sour milk better than they did raw or pasteurized milk. This was for many years attributed to the lactic acid bacilli, until some bright mind wondered if the acid itself might not have something to do with it. Accordingly milk was acidified with lactic acid alone to the same degree that it usually becomes acidified through fermentation. This worked. Then others wondered if other acids worked in the same way, which indeed they did. The medical litera-

ture of the day was flooded with articles on the acidification of milk with different acids: citric acid, vinegar, hydrochloric acid, lemon and orange juices all called forth contributions to medical journals. In this period we learned that boiled milk was better than raw milk, that sour milk was as well tolerated as any milk, that evaporated milk was safe, chiefly because it was sterile; and that any sugar could be added to the formula, provided sufficient was given, and that the cheapest sugar was therefore the best.

Two other principles had gradually come to be understood in this period of progress toward simplicity. The one was that the infant must receive enough food: approximately two ounces of milk per pound of body weight for every twenty-four hours, with about an ounce of any sugar for every twenty ounces of the mixture, and water sufficient to make the total fluid intake three ounces per pound of body weight per day, more or less. This means very simply that an infant requires two-thirds boiled milk and one-third boiled water; or if evaporated milk is used, it is one-third evaporated milk and two-thirds boiled water, with sugars as already indicated. The whole divided into the number of feedings that the child takes, usually five, occasionally only four or even

The other principle was that the vitamins, particularly D and C, must be provided in adequate amounts from a very early age — a few days really — and throughout the first two years of life. From whatever source, an amount of oil must be given which will provide the infant each day with about 1000 units of vitamin D and sufficient fruit

juice to yield between 30 and 50 mg. of vitamin C. This means an ounce or two of orange juice, or two or three ounces of tomato juice, or the pure vitamin in the doses mentioned. With these three principles always in mind—sterility, adequacy, and vitamins — the methods used in attaining these ends are of no importance. The goal is important; the manner of arriving at it is of less significance.

Present trends in infant feeding are all towards simplicity. Formulas which used to be changed by the doctor about once a week are now hardly changed at all. Spoon feeding with semi-solids, once withheld until the second half of the first year, are now given as early as six or eight weeks, rarely later than three months, and the variety of foods offered is limited only by the ingenuity and daring of the physician. These are steps in the right direction, and they are in the main responsible for the increasingly diminishing death rate among young infants, and for the generally improved nutritional state of artificially-fed infants virtually everywhere in the civilized world.

We have come a long way from the empiricism of a generation ago, and we are approaching the scientific attitude of inquiring into the reason for all that we do in infant feeding. We have ironed out most of our difficulties, and we have finally relegated the whole subject of infant feeding to its proper place in pediatrics. We are left with the never-ending task of studying and attempting to understand and, when possible, to cure the manifold and complex diseases of infancy and childhood. From baby-feeders we are gradually becoming physicians for children — or pediatrists.

Preview

Periodically we hear a suggestion that there is such a person as a "born nurse". Whether there is or not, there are definite characteristics which the *ideal* nurse should have. L. Evelyn Horton has put down her ideas for us of what these ideal characteristics include. Perhaps you would like to add others after you read her article in the May issue.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A

Teaching Microbiology

BLANCHE MCPHEDRAN

A novel situation always creates interest. In introducing a course of Microbiology, the instructor has this advantage as very few students have had any instruction in this subject. Microbiology is one of the basic sciences of the preliminary curriculum. It is basic in that it provides a suitable, scientific foundation upon which many nursing principles are established. A knowledge of microbes, including their life activities and method of transmission, gives to the details of aseptic technique an interpretation of increased significance.

A suitable course of microbiology for nurses should place the emphasis upon the pathogenic aspects of organisms studied. Some time must be devoted to an evaluation of the beneficial effects in industry and public health of certain un'cellular plants and animals.

Interest may be augmented at the beginning of the course by taking cultures from the students' hands, pens, unform, or from such articles as door knobs and light switches. In twenty-four hours a blood agar or beef broth medium is rich with bacterial colonies. These same cultures may be used in a subsequent lecture to demonstrate shapes and arrangements of organisms.

If nurses are to protect themselves and teach hygienic principles to others, they should understand how organisms are transferred, how they enter and leave the body, as well as the mechanisms by which the body protects itself. In a community health program, no nurse would be considered adequately qualified unless she had a thorough knowledge of vaccines and sera; their preparation, indications for administration, time interval and quantity of each dose.

From the foregoing aims, it is evident that nurses are not being prepared as science specialists. This fact may be forgotten by the instructor in her eagerness to secure perfection of technical details in the practical aspects of the work. A break in technique would constitute a real hazard if students are permitted to handle such organisms as streptococcus hemolyticus, bacillus tuberculosis or other equally virulent specimens.

In no subject may the compatibility of theory with practice be better demonstrated than in microbiology. At least one-half of the total number of hours should be spent on practical work, and where possible the closest correlation between theory and practice should exist. For example, a period subsequent to a lecture on the history of the subject would be a judicious time to demonstrate the mechanism of the microscope and provide practice in its use. Or again, following a lecture in disinfection, the students should experiment with common mechanical and chemical methods.

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A direct application of these principles may be secured by a visit to an isolation unit or operating room.

Adequate equipment is of prime importance for a successful course in microbiology. The 'students' laboratory should include at least: 1. facilities for culturing bacteria; 2. microscopes; 3. common bacterial stains; 4. centrifuge. The hospital laboratory may supplement such articles of equipment as an incubator, water baths, autoclave, animal cages, suction pumps, anerobic jars, and pathological specimens.

Part of the course should be devoted to the collection of specimens. How to avoid contamination of specimen, collector or handler should be emphasized. This suggests a practice where students may take throat cultures, later preparing, staining and examining bacterial slides.

Where the length of the course permits, a very vivid way of teaching immunology is by animal inoculation. Another satisfactory method is to correlate this instruction with the students' health program.

Following the preparation of bacterial slides, the students should be given an opportunity to stain and examine the organisms, using the oil immersion lens of the microscope. For beginners, this is a rather slow procedure, so that the instructor may wish to supplement this experience in one or both of the following ways: Most textbooks abound with authentic colour reproductions of organisms. Used with a projector, these prints are an effective way of demonstrating important points. Another timesaving device is the micro projector. This equipment attached to a microscope

makes possible the projection of the actual bacterial forms, very much enlarged, on to a screen. This is a particularly suitable method, as it gives the instructor an opportunity to point out salient features which she can never be sure the student actually sees.

Correlation between the pathogen and the disease it produces is effective when the students see the clinical features. "Streptococcus Scarletinae" may be a meaningless term until the bright red rish or strawberry tongue of the patient leaves an indelible imprint on the learner's memory. At the present time when viruses are, for practical purposes, still ultra-microscopic, they seem more realistic if the students can see a patient suffering from "Measles" or "Chickenpox". In lieu of the actual patient, a coloured plate from a textbook may be effectively employed.

The value of student participation can never be over estimated. In addition to laboratory practice, progress may be enhanced by utilizing facilities provided by the community. The fascination with which students watch milk being processed or water being purified, bespeaks the value, not only as a learning situation, but as a stimulus to interest in the field of public health.

The following is a resumé of a combined course of lectures in microbiology, hematology and pathology. The number of hours devoted to this course is thirty-two—sixteen to 'theory and sixteen to practice. Although it may appear as if each laboratory period is subsequent to the lecture of the same number, the sequence is indicated by the number appearing in parentheses after the laboratory practice number:

THEORY:

- 1. General introduction: aims, history.
- 2. General study of microorganisms: fungi; protozoa; viruses; bacteria.

LABORATORY PRACTICE:

- 1. (1) Microscope mechanism; care; use. Principal laboratory equipment.
- 2. (2) Use of microscope: instruction and supervision in taking cultures.

- 3. General study of bacteria: distribution; growth; methods of study.
- 4. Classification of bacteria: identification of bacteria.
- 5. Useful bacteria: infection resistance; virulence; portals of entrance and exit; mode of transfer and prevention.
- 6. Disinfection: mechanical; physical; chemical.
- 7. Immunity: introduction; antigens and antibodies; classification.
- 8. Immunity: vaccines and sera; preparations used; relation to health program.
- 9. 10. 11. Study of common pathogenic bacteria: appearance; growth requirements; staining; pathogenicity; prevention of disease. The more common virus and protozoan diseases.
- 12. Pathology: causes of death, other than bacteria; value of examination of specimens; nurse's role in collection of specimens.
- 13. Pathology: tissues; neoplasms, degenerative changes; congenital defects.
- 14. Blood: normal; calculating number of cells; classification of anemias.
- 15. Blood: sources of blood for examination; blood chemistry; blood culture; Wassermann and Widal reaction.
- 16. Inflammation: causes; phagocytosis; resolution; exudates.

- 3. (3.4) Study of cultures prepared in laboratory 2: preparation of slides; demonstration of staining; dark field illumination; sugar reactions.
- 4. (6) Demonstration of disinfection by: boiling; chemicals; surgical scrubbing; cultures made before and after each.
- 5. (3.4) Preparation of slides from cultures of laboratory 4: staining Gram's and acid-fast methods; demonstration and explanation of agglutination and pneumococcic typing.
- 6. (6. 9. 19. 11) Examination with microscope of slides prepared in laboratory 5: lantern slides of common pathogens.
- 7. (6) Sterilization: central supply room; medical aseptic pantry.
- 8. (6) Pasteurization: community dairy visits.
- 9. (12. 13) Pathological specimens and slides of tissues.
- 10. (14.) Demonstration of hemoglobin estimation and complete blood cell counts; preparation of blood films.
- 11. (14. 16) Examination of slides exemplifying abnormal hematological conditions: anemia, leukemia, leucocytosis, leucopenia, eosinophilia, lymphocytosis.
- 12. Staining and examining blood films prepared in laboratory 10.
- 13. (15) Demonstration of blood typing and grouping: relation to blood bank.
- 14. (16) Process of resolution demonstrated by diagrams and slides; technique for taking and value of blood culture.
- 15. (14. 15) Demonstration and explanation of bleeding time; coagulation time; sedimentation rate; fragility test.
- 16. Demonstration by diagrams and models of common parasites: nematodes; cestodes.

After having taught a course in microbiology, most instructors would agree that the following questions are worthy of consideration: 1. Should microbiology be taught as a separate subject? 2. Could it be integrated with other subjects such as medicine, surgery, hygiene, communicable diseases and so prevent duplication of instruction? 3. Would a brief introductory or elementary course given in

the preliminary term avoid the difficulty, exhibited by beginning students, in comprehending technical information?

The foregoing outline, with suggestions, has been used by the writer. From experience, it has been found to be practical, to provide for student participation, and to be valuable using student achievement as an index for appraisal.

Another Flood

Have you ever seen a rampaging river in flood? Or have you been in the vicinity of an avalanche? There is nothing that mere human beings can do to stop either. Ever since the turn of the New Year the Journal has been experiencing a flood — a flood of new subscriptions. We would not want to stop it for anything but, like the avalanche, it was so unexpected that we were caught unawares. The hundreds, yes, literally hundreds upon hundreds of new subscribers wanted to read a particular issue and asked to have their Journals start with a certain month. We are sorry but there is no way we can secure more when our supply for any one

month is exhausted. We can only hope that copies have been shared so that none has missed the articles desired. Perhaps we should consult a soothsayer or a numerologist to give us advice on how many copies to order! We jumped the order eight hundred from January to February, five hundred from February to March and, as this is being written, have no way of knowing just what we will have to order for April. Will the new subscribers forgive the late starts? We are trying hard to provide you with the best nursing journal you can secure, in as large quantities as we require. Sometimes you surprise us!

—M.E.K.

Health of Workers Matter of National Concern

The Health League of Canada's "plan for health education and medical supervision in Canadian plants appears to fill a real need throughout our industries", it was stated in a message sent to the Industrial Division of the League by Hon. Brooke Claxton, Minister of National Health and Welfare.

This plan — developed in co-operation with the Ontario Department of Health — advises industrialists (1) how to start and operate a medical program for workers; (2) how to improve eating habits of workers; (3) how to maintain health of workers with a practical educational campaign.

In his message, Mr. Claxton said the Industrial Division of his Department is actively interested in the promotion of health among Canadian industrial workers.

"The health of Canadian workers is a matter of national concern, not only now when our war supplies are so urgently needed, but during the peace and reconstruction period to which we all so anxiously look forward.

Your plan deserves every success in Cana-

dian industry, and we shall watch its advancement with a great deal of interest. I hope that individual industries and the Health League will feel free to call upon us for advice and co-operation at any time in any matter related to industrial health. This Department's only purpose is to promote the health and welfare of the people of Canada".

In re-endorsing the plan, Hon. Humphrey Mitchell, Federal Minister of Labour, wrote that "it is obvious to me that great care and intelligence has been used in bringing to the front the facts which have to do in a vital way with the well-being of those who toil . . . I feel sure that your program, if adopted by our industries, will contribute in no small way to a more effective war effort".

Hon. C. D. Howe, Minister of Munitions and Supply, in another re-endorsation said that "the general adoption of this plan by industry will do much toward reducing absenteeism in industry caused by illness and, therefore, the plan is important to our wartime objective."

-Health League of Canada

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

Toxemia of Pregnancy

MARGARET MCNEILL

At Prince County Hospital, Summerside, Prince Edward Island, not long ago, I was asked to special Mrs. M, a primipara, thirty-seven years of age, Roman Catholic and a farmer's wife. This primipara was seven and a half months pregnant and I understood from her physician that she had given him much cause for concern for several weeks.

The patient was vomiting frequently, pale, very drowsy and showed considerable edema about face and legs. She did not have a headache. The physician told me that before admission blood pressure was 171/123, but on admission to hospital, and at rest in bed, it dropped to 158/122. Her urine showed albumin XX with some granular casts. The red blood count was 3,910,000; white blood count, 6,300; hemoglobin 80 per cent. Evidently, I had a two-fold problem; a very sick primipara, and an unborn, living baby.

My instructions were to keep my patient exceptionally warm with woollen blankets and dry heat. Visitors were not allowed. Diet was fruit juices, milk, and plenty of hot lemonade. This produced free sweating. She was given repeated intravenouses of glucose and saline. Small doses of Phenobarbital were given for restlessness, supplemented by Heroin grs. 1/12 the first night.

In the first twenty-four hours the

urinary output was ten ounces. As sweating was profuse and vomiting had ceased, the physician was satisfied to continue the same treatment. After ninetysix hours, the urinary output suddenly increased, and the patient seemed greatly improved; blood pressure dropped; all nervousness and stomach symptoms disappeared. Her improvement continued for ten days, when she showed signs and symptoms of impending disaster. At this time the urinary output was twelve ounces in twenty-four hours; albumin XXXX and blood pressure climbed to 174/110. Headache became a prominent feature with slight visual disturbances. My patient was now eight months pregnant, Since she did not respond to treatment a Cesarean section was done that evening.

Before going to the operating room special care was given to the preparation of the abdomen. It was scrubbed with green soap and water, carefully shaved, then cleansed with ether and alcohol, and sterile towels and binder were applied. The patient was catheterized. No sedation was given. The operation was without event, and she was delivered of a living six-pound healthy girl.

Mrs. M's convalescence was remarkably free from complications; urinary output was good; blood pressure settled down to within normal limits, and

all other symptoms of toxemia disappeared. She left the hospital on the four-teenth post-operative day.

The interesting sequel to this case is, briefly, as follows: The patient again became pregnant seven months later and was admitted to hospital in nine months as a full-term pregnancy, with very slight pains and no evidence of toxemia. The fact of an uncomplicated second pregnancy definitely established the diagnosis that it had been a case of true toxemia of pregnancy, and not a case of chronic nephritis with a breakdown due to the stress of pregnancy. Mrs. M. was prepared for any emergency, and the physician decided to give her a short test of labour. His instructions were to keep a careful watch for any radical change in her condition. On the afternoon of the day following her admission to hospital, the patient began to have definite signs of labour when, suddenly, she complained of severe generalized pain in her abdomen. Her physician was called and found her in marked shock. He made a diagnosis of a ruptured uterus. A laparotomy was done immediately. On opening the abdomen the uterus was found to be ruptured, and the baby's head only was protruding through the rent in the uterus. There was practically no blood in the peritoneal cavity. A dead baby was delivered. The uterus was closed and the operation was completed in the usual manner. The patient made an uninterrupted recovery.

In discussing the case, the physician pointed out the danger of a ruptured uterus in subsequent pregnancies following Cesarean section. The dictum "Once a Cesarean, always a Cesarean", is particularly true in a case where a section is done for toxemia of pregnancy. Due to the constitutional disturbances in toxemia of pregnancy tissue healing is of a poorer quality than in a healthy individual.

If Mrs. M again becomes pregnant she will run a considerable risk to her own life, and will undoubtedly be advised to have a section done at term and before the onset of labour.

Of Historical Interest

A little-known story of peculiar Canadian interest is attached to the life of Florence Nightingale.

In early life, Florence Nightingale was engaged to her first cousin, John Smithurst of Derbyshire, England. Marriage was forbidden by both families, probably on grounds of consanguinity. Mr. Smithurst eventually entered Holy Orders and went out to minister to the Indians at Fort Garry, later to be known as Winnipeg.

In 1851 the Reverend Mr. Smithurst returned to England. Whether he still hoped

that a marriage was possible is mere conjecture, but it is significant that it was in this year that Miss Nightingale made a final decision to give her life to nursing. Miss Nightingale entered the Deaconess School at Kaiserswerth. Mr. Smithurst returned to Canada and became rector of the Anglican Church at Elora, Ontario. He died there, and lies buried in the old churchyard. The silver communion service still in possession of the church at Elora was a gift from Florence Nightingale in 1852.

-N. L. BURNETTE

Preview

Following up the discussion on industrial hygiene which appears this month, Mrs. Lois Grundy has prepared a detailed account of a program in action. The mushroom growth of the ship-building indus-

try on the Pacific coast during the war years provided the opportunity for the development of a very broad plan for the supervision of the health of thousands of employees.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses
Association

Far Be it From Me to Boast - But

SHEILA C. MACKAY

We are a progressive race, we Albertans - at least we like to think of ourselves as such — and sometimes we do something that would really seem to indicate that we are. Now, take for instance, the summer school for graduate nurses that has been held during the past two summers, under the auspices of the A.A.R.N. at the University of Alberta. We're proud of that summer school. As yet, it is the only one of its kind in the Dominion of Canada. And not only is it helping to meet, in some measure, the great need of the province for trained personnel in the public health and teaching and supervision fields, but also the needs of many of our nurses, who, because of lack of time or funds, have previously been unable to take this post-graduate work.

It includes the two courses — ward teaching and supervision, and public health nursing. Instruction is given over a period of ten weeks each summer and the successful completion of one such summer's work, in either field, qualifies the nurse for a certificate of attendance and standing. A student with university entrance qualifications will receive consideration for the credits obtained, should she wish to register in the Bachelor of Science degree course in the future, and all this for an amazingly small fee. The bulk of expenses attendant upon conducting the school is

defrayed by the A.A.R.N. Even the necessary textbooks, as well as any amount of supplementary reading material, are supplied through the Association Library.

Thanks to these courses, forty-seven inspired women stepped from our campus on August 5, 1944 — twenty of them bravely resolved that student nurse training and hospital administration should henceforth be pursued upon a much higher plane; twenty-seven valiantly intent upon enticing the man on the street into fervently desiring good health, and all forty-seven staunchly determined to apply the scientific approach to every imaginable life situation, from learning to drive a car on muddy roads to convincing student nurses that anatomy and physiology is interesting.

In all seriousness though, the word "inspired" is used advisedly. Goodness knows how we looked, but we felt inspired, for our courses were so designed as to be eminently stimulating and thought-provoking and, withal, practical. They were made more so perhaps because many of our number had had several years of experience in their respective fields and had come to the University laden with unanswered problems — problems which, of course, we solved. In fact, any problem in either course that couldn't be thrashed to a solution in class (a theoretical solution.

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at least) was unsolvable. Miss Nightingale herself — or even Houdini — would have been stuck by such a problem!

We naturally cannot give you the curriculum in its entirety, but there were a few highlights which we can't restrain ourselves from mentioning: our fifty-seven hour course in mental hygiene from Dr. Samuel Laycock of the University of Saskatchewan — our lectures in nutrition from Dr. Jennie Rowntree of the University of Washington (both of these subjects were taken jointly by the two sections) - our seminars in public health nursing our panel discussions in nutrition those lessons in materia medica that the T. & S. girls had to teach (they'll never forget them!) - the impromptu speeches that the P. H. Section nobly quavered through - the too-fleeting glimpses that we caught of Miss Kathleen Ellis, then Emergency Adviser of the C.N.A., and of Dr. Pett, Director of Nutrition Services of the Dominion Government.

Then there were our eighteen hours of study in Contemporary Nursing Problems (another joint subject) hours, all too brief and too few, packed to capacity with analyses, discussion, and the occasional disagreement. We know now why professionalism rather than trade unionism is desirable for nurses, as well as innumerable other "whys and wherefores" of the nursing world. What is more, we know our present day nursing leaders. We know them because we were given an assignment, "Go find ten nursing leaders of today," we were told. "What have they done? What are they doing? What are they apt to do?

And bring them in alive and kicking!" - or words to that effect. And we did as we were bidden with a mighty will. We ransacked files and drove librarians psychotic. We did everything but write to the Wartime Information Board. We venture to say that never before have so many illustrious ladies been dragged mistakenly from retirement and hurriedly thrust back again! But we learned something from that assignment. We not only learned who are our leaders and where they are leading us, but we stepped, for a brief moment, on to the heights where they are standing, saw the visions that they are seeing, and knew surely that the future of nursing is safe in their hands, for their dreams are good, and their will to accomplish burns strong and unquenchable.

We would like to tell you more of our summer school, of our picnics and how we learned to jujutsu, of our gettogethers, and how good the doughnuts were. Of our encounters with the Navy (whose quarters, believe it or not, all but surround the A.A.R.N. Library), and of how it whistled at us, glory be! and almost swept us out to sea every day. But space — and dignity — do not permit.

We can only sum up by saying that those who arranged and directed our activities did everything in their power to make our courses of vital and practical value to us. They made us work. They made us think. They played with us. And they sent us out with a solid groundwork of knowledge and a wealth of inspiration that we won't soon local.

What more could possibly be desired? Nothing, we think.

Flash!

Calling all graduates from the McGill School for Graduate Nurses! Please take about five minutes to jot down your name and address and send it in time to have it reach the secretary-treasurer, Miss Rosemary Tansey, Montreal Convalescent Hospital, 3001 Kent Ave., Montreal, P. Q. by May 15.

Summer School for Graduate Nurses

MADELINE MCCULLA

The School of Nursing of the University of Alberta, at the request of and under the auspices of the Alberta Association of Registered Nurses, has conducted a summer school for graduate nurses for the past two seasons. The project was financed by the Government Grant given to each province through the C.N.A.

During the summer of 1943 the School was under the direction of Miss Helen G. McArthur, M.A., then acting director of the School of Nursing. Special lecturers were Miss Rae Chittick, M.A., director of health education at the Normal School in Calgary; Dr. S. R. Laycock, professor of educational psychology, University of Saskatchewan. The instructional staff during both sessions included Miss Helen E. Penhale.

M.A., of the teaching faculty of the Division of Study for Graduate Nurses, University of Western Ontario, who was responsible for the courses in ward teaching and supervision.

The summer of 1944 found some staff changes with the School under the direction of Miss Madeline L. McCulla, M.A., new acting director of the School of Nursing. The special lecturer at this session was Miss Jennie Rowntree, Ph. D., professor of home economics, University of Washington.

The course has fulfilled a very de'inite need during this wartime emergency by providing qualified graduates for many vital spots in the public health field, and instructresses and ward teachers for schools of nursing in the province.

Boosting Morale in the V.O.N.

CHRISTINE LIVINGSTON

The morale of Victorian Order nurses throughout Canada is high these days because of various progressive measures recently enacted on their behalf by the National Executive of the organization. These measures include the awarding of scholarships to assist nurses to take post-graduate training in public health nursing; the provision of an initial uniform allowance; and the establishment of a plan for retirement annuities.

The Victorian Order of Nurses, as other public health nursing organizations, has been endeavouring to maintain standards and policies in the face of a continuing shortage of adequately trained personnel. During the war years,

the demands for the service have increased, new branches have been opened and in some localities the program has extended to a part-time service in industrial plants. A further expansion is expected in the post-war period, when the Victorian Order will be co-operating with official and voluntary agencies in future health programs for Canada.

To more adequately meet the present demands and to be prepared for future developments, the Victorian Order is endeavouring to increase the supply of well-qualified public health nurses by the awarding of scholarships. The amount of each scholarship offered by the National Office to nurses who have graduated

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A welcome visitor.

from accredited schools of nursing is \$500. The candidates agree to serve one year with the Order on the completion of their public health course. In addition to those provided for one year's post-graduate training, financial assistance is sometimes given to Victorian Order nurses for advanced study on a supervisory level. Although the scholarships are awarded nationally, regional recruitment is encouraged.

The second development deals with the question of a uniform allowance. It has been realized that the initial expense of purchasing uniforms has created some degree of difficulty to new nurses com-

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ing on the staff of the Victorian Order. Therefore, a recommendation was forwarded to the National Executive from the Advisory Committee on Nursing and from the conference of Victorian Order nurses held in January this year that the payment of an initial sum of \$75 uniform allowance be made to nurses on appointment to the staff for at least one year. This recommendation was approved by the National Executive and became effective February 1, 1945. Although the arrangement is an experiment undertaken by the National Office, there is indication that, following the demonstration period, the project may be continued, as many of the branches have expressed their willingness to participate locally in the plan for uniform allowances.

The third measure is concerned with a plan for retirement annuities for nurses. For many years there has been hope that such a plan would be provided for Victorian Order nurses and now this hope has been realized. Largely through the personal generosity and effort of the national president, Mr. J. W. McConnell, a fund for retirement annuities has been established and it is expected that the plan will be in operation before the end of 1945. Although the details of the project are not yet complete, a government annuity plan under consideration provides for a threeway contribution, shared by the National Office, the local branch and the nurse.

A Post-Graduate Course in Psychiatric Nursing

CATHERINE LYNCH

The announcement that a postgraduate course in Psychiatric Nursing has been approved by McGill University opens up a new avenue for the preparation of nurses in a clinical specialty. That psychiatric nursing should have been selected is encouraging to those who are already bending their efforts in an endeavor to prepare nurses in this field.

Articles have appeared in The Canadian Nurse and the American Journal of Nursing setting forth the need for psychiatric experience in pediatric nursing, in orthopedic nursing, and in industrial nursing and asking that the means

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for nurses to become qualified be made available. We have been brought face to face with the urgency for adequately prepared nurses in mental hospitals through the Survey made by the Canadian Nurses Association. The need cannot be overemphasized.

There is an abundance of clinical material in psychiatric departments of general hospitals and in mental hospitals. In order to use this to advantage we must prepare head nurses, teachers and administrators who in turn will plan teaching programs for affiliating and post-graduate students. The setting-up of a well-administered post-graduate course should not cause us to lose sight of the need for experience in the undergraduate course. This applies to psychiatric nursing just as it does to surgery, pediatrics and obstetrics. The student nurse, until she has been taught to understand behaviour in the person who is not ill, does not look objectively at the symptoms presented by the mentally ill patient. To understand the well person, to recognize symptoms in the ill person, and to learn to utilize varied approaches to different patients, should be included in the aims of the under-graduate course. The post-graduate student who has added to her basic course one year of satisfactory nursing experience, and has demonstrated aptitudes and abilities necessary in the field of psychiatric nursing will develop her understanding to the point where she is able to adapt effective nursing care for the patient whose behaviour limits him in the acceptance of this care. Miss Eva Moore has given us an excellent example of this in her description of the elderly patient with a cardiac condition whose concern for his son made it difficult to keep him in bed. The experienced nurse helped him solve his difficulty, making it possible for him to get the bed-rest his physical condition required.

This illustration brings up another point. The psychiatric nurse must have

a thorough knowledge of the nursing of the various physical ills from which the patient may be suffering. Medical conditions occur just as they do among any group of people and they are cared for in the same way. Surgical conditions, although not appearing so frequently, call for good surgical nursing care.

In the December, 1944 American Journal of Nursing, the Committee on Post-Graduate Clinical Nursing Courses has with clarity classified, defined and described types of clinical courses. In the March issue of The Canadian Nurse Miss Lindeburgh wrote on "What Constitutes Post-Graduate Clinical Courses". She has set forth the principles of administration and this firm foundation gives strength to the aims of this new course which are:

- 1. To develop a broader understanding and greater skill in nursing mentally ill patients by becoming more proficient in the recognition of symptoms and the interpretation of behaviour.
- 2. To assist the nurse to acquire the knowledge and ability necessary to participate in a program for the prevention of mental illness and the promotion of mental health in the community.
- 3. To prepare this nurse specialist to administer a psychiatric nursing service and to assume supervisory responsibilities in relation to the care of patients and the development of the teaching program for student nurses.

The course will open with one month devoted to observation. This will include services selected for their clinical value, and time and opportunity to observe. The value of early recognition of the illness and seeking of medical assistance will be demonstrated as well as the methods used in bringing about recovery. The nurse will be guided in acquiring a good technique of observation. There will be supervised experience in the care of the various types of mentally ill patients, and practice in such

forms of therapy as shock, occupation and recreation. Beginning the second month, lectures will be given in McGill University and the School for Graduate Nurses, including Psychology, Sociology, Mental Hygiene and Child Psychology, Trends and Developments in Nursing, Public Health and Nursing, Psychiatry and Psychiatric Nursing. Correlation with progressive stages of clinical experience will be accomplished through conferences, clinics, demonstrations and special studies. During the last three months of the course an intensive clinical program is planned to provide supervised practice in Ward Administration, Supervision, and Teaching.

The facilities of the Allan Memorial

Institute of Psychiatry of the Royal Victoria Hospital, the Verdun Protestant Hospital, an institution of 1500 beds, and other community agencies will be used for experience and teaching.

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Obituary

Christina M. Dick, for more than twenty-five years in charge of the nurses' home of the Johns Hopkins Hospital, died recently at the Johns Hopkins Hospital in Baltimore. Miss Dick was born in Brampton, Ontario. She graduated from the Johns Hopkins Hospital School of Nursing in 1899, and had a long and distinguished career.

Prior to the last position which she held for so many years, at various times she held the following positions at the Johns Hopkins Hospital: private duty nurse, head nurse, night superintendent, assistant superintendent of nurses, and instructor in the practice of nursing. In Idition, she was superintendent of Rainbow Cottage, Cleveland, Ohio, from 1904 to 1905; superintendent of the Baltamore Eye and Ear Hospital from 1906 to 1910; and superintendent of Grace Hospital, New Haven, Connecticut, from 1912 to 1914.

Burial was in Brampton, Ontario. Mis Dick is survived by her sister, Miss Elimbeth Dick, who is also a graduate of th Johns Hopkins Hospital School of Name and appointed to that staff.

Regarding our Official Directory - Attention!

In our June issue the complete Official Di ectory will once again make its quarterly appearance. Will all Associations, which have not already done so, please send us their lists of new officers at once. (Don't forget to include the Secretary's address.) Remember we cannot keep your announce-

ments up-to-date unless you co-operate by forwarding us the latest information as soon as it is available. In spite of careful checking on our part, mistakes do creep in. So check your announcement as it now appears in the March issue and let us have your corrections and changes.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

National Conference of Women

In all parts of Canada women have been preparing themselves for the postwar rehabilitation era. On Thursday, February 1, under the aegis of the National Council of Women, the first conference of Canadian Women's National Organizations met to contribute to the discussions and findings, Fiftythree organizations were represented. H.R.H. Princess Alice sent a message of greeting, expressing her pleasure that so many affiliated groups had joined in an agenda which covered the whole field of the social and economic welfare of the country's present and future. She stressed that women "through the war, have found a very real place in the public and structural life of the community and nation", and expressed the hope that "women will have places in all the different departments being set up for relief, rehabilitation and reconstruction."

The Importance of the Home was the first item on the agenda and was led by Mrs. R. B. McElheran, Toronto, president of the Anglican Women's Auxiliaries and Mrs. Roger Self, president of the United Church Women's Missionary Societies. Attitudes to women and the home are changing with time, said Mrs. McElheran in speaking of "marriage-a full-time job". Modern practices tend to separate members of families, and she suggested that marriage should be considered a way of life, not a job. Neglect of religious training was blamed by the speaker for the disintegration of home life.

Partnership in Family Life was led

by Mrs. Harvey Agnew. Employment and Social Security was led by Miss Margaret Hyndman, K.C. and Alderman Hilda Hesson of Winnipeg.

Single Women in Business and Professions was the subject for discussion at the afternoon session. Miss F. Munroe, president of the Canadian Nurses Association, outlined the organization of the Canadian Nurses Association and the present situation with regard to nursing and nurses. Miss Marion Lindeburgh, convener of the Postwar Planning Committee, outlined the work of her committee.

That there will be great opportunity for young women in the post-war era as home economists, dietitians and nutritionists was emphasized by Miss Mary Clarke.

The Household Help Problem, which has become exceedingly acute during the war, lies with the woman employer, maintained Mrs. Harvey Agnew. It is largely within her power to change present attitudes and solve the problem. Resolutions sent to the committee which will deal with these matters suggested that pressure be brought to bear on Dominion and Provincial Governments to implement at once a training program for household helpers; also that the naorganizations · undertake campaign of education of women employers as to conditions of the houseworker.

Dr. Edna Guest spoke on the need for a national health program. Need for a physical fitness program was made clear in the great number of military service rejections.

Dr. Vibert Douglas, Dean of Women at Queen's University, stated that education is fundamental to citizenship. She believed that there should be greater uniformity of standards in the provinces, better salaries for teachers ---"those in some places being iniquitous and none too good, at best". More emphasis on the spiritual development is essential, Dr. Douglas asserted, speaking of the Bible as a great treasure house of wisdom and literature, which should be taught. Better school trustees are something the electors can easily demand, and women can help obtain this end, she said.

A resolution stressed the necessity of recruiting and training adult leaders for 'teen age children, and another urged the establishment of nursery schools as an extension to the education system.

An amendment to the Housing Act, so that the municipalities, provincial and federal governments would co-operate in subsidizing housing for low-wage families, was approved.

Loss of so many young men in the war has presented a challenge to women of talent and ability to step in and fill the gap, and it is up to older women, at present leaders in government and community, to encourage these young women, said Senator Iva Fallis, speaking on Women in Public Life. She doubted whether women of Canada have in any large numbers made a determined effort to fit themselves for public life; women are accepted in business, in the professions, why have we not come to be regarded as necessary to public life!

Senator Cairine Wilson stressed the need for more women representatives on public boards and committees, as well as in Parliamentary life, and praised efforts of pioneer women who had agitated for reform. The cause of women representation, she said, "must be pressed without bitterness, without intolerance or impatience". It is weak and foolish for women in possession of full citizenship to go knocking at the back doors

of governments asking for appointments was the statement made, by proxy, by Alderman Frances Henderson of Hamilton. Everything we do, or try to do, for society is superficial unless we increasingly gain positions in governments — local, provincial and federal.

Responsibilities of Citizenship was the subject of the discussion at one of the later sessions. Miss Joy Maines, president of the Canadian Association of Social Workers, spoke on juvenile delinquency as a problem for community action, and pointed out that there is too little emphasis on parental responsibility.

More complete co-ordination of all adult educational activities on a community level was suggested by Miss Elizabeth Long; also a nation-wide public library service — 54 per cent of Canadian population is without this service at present.

Demobilization of women from the services and industry was summed up by Squadron Officer Jean Davey, R.C.A.F. (W.D.). She suggested that people should not look upon women leaving the services as problems to be adjusted. They should remember that these women have had unusual and valuable experience, which will enable them to make a real contribution to the country—"Let them see you expect leadership and responsibility from them and you will get it."

Mrs. Donald A. McKenzie, of the Canadian Red Cross, spoke on the war brides, explaining the procedure of the Society in looking after these young women from the time they leave Britain until they are turned over to I.O.D.E. and church groups in Canada.

The conference ended with a panel discussion on National Unity. "Our boys are fighting together and dying together on the battlefields — it does not matter to what race they belong; they are Canadian, they are ours", said Madame P. W. Marchand, who for thirty-two years had headed the Federation des Femmes Française-Canadienne.

Mrs. Harold Lorie, head of the National Council of Jewish Women, spoke on behalf of the 165,000 Jews in Canada. She emphasized the fact that the Jewish people, with 1,647 enlistments and a great volume of war work done by the women, were "patriotic and loyal".

Mrs. B. Dyma, Winnipeg, told what the Ukranians have accomplished in the agricultural life of their adopted country. Forty-nine per cent of Ukranians in Canada are farmers, she said; there are over a thousand teachers and a considerable number of other professions.

The resolutions committee took over the task of preparing planks for future action. The Canadian Nurses Association submitted the following resolutions:

- 1. That the National Conference of Women endorse the request of the Canadian Nurses Association for representation on the Dominion Health Council;
- 2. Whereas the Canadian Nurses Association recognizes the place of subsidiary nursing groups and has demonstrated its interest by the setting of standards for the training of such workers; and whereas the Canadian Nurses Association is agreed that in order to ensure the safety and protection of the public, any program for the preparation of subsidiary nursing groups should not be implemented until Provincial Governments pass legislation for the licensing and control of subsidiary workers; therefore be it resolved that the Conference of Canadian Women's National Organizations here assembled endorse the policy of the Canadian Nurses Association, namely:

That preliminary to the establishing of training courses for subsidiary nursing groups, Provincial Governments pass legislation for the licensing and the control of such workers.

United States National Nursing Council for War Service

The United States National Nursing Council for War Service has for some time provided the Canadian Nurses Association with reports of the activities of the Council. We were very much interested in a recent report given by Miss Lucile Petry, Division of Nurse Education, United States Public Health Service, which contained an outline of the effects of the Nurse-Cadet program on nursing education. These included:

- 1. Improvement in the quality of applicants throughout the country.
- 2. Improvement in educational programs because of having a little money to spend on libraries, laboratories and other institutional facilities.
- 3. Increasing interest on the part of colleges in nursing education.
- 4. Improvements in nurses' residences through allotments of Lanham Act funds to Bolton Act connected projects.
- 5. The tendency of the program to focus the school's attention on its budget.
- 6. More applicants have learned the characteristics of a good school of nursing.
- 7. The amount of service contributed by students has prevented a collapse of nursing service in hospitals. Although only 1,234 or 29 per cent of the non-Federal general hospitals have schools, those with schools handle 56 per cent of the patients. Student service in hospitals with schools average 60 per cent.

Nursing and Nursing Education in the Future: In newspapers and magazines, reference has been made to a proposed integrated hospital system which would be part of a plan to give all citizens equal opportunity for "the full benefits of good medical care."

This plan refers to an integrated hospital system with a base hospital serving as a centre of research and teaching. Each state would have at least one of these hospitals, some of which will have a medical school connection. In addition, there would be district hospitals, a little smaller, carrying all the major services and taking all but the most complicated cases. The district hospitals would receive as patients from the next

smaller units, the rural hospitals, the cases they are not equipped to care for. Still further removed would be the health centre, a combination of the local health officer's office, the public health nurse's office, dental clinic, etc. There would be an interchange of both personnel and patients in this integrated system of hospitals.

Nursing care would be given in all four types of hospital and health centre situations described above, in public health nursing agencies and in homes, by a combination of professional and

vocational nurses.

In the educational system fewer and better basic schools for professional nurses would be needed. Most of these schools would use base hospitals for clinical fields and would be parts of universities. The district, rural and health centre situations would be used on an affiliation basis. All nurses would be prepared thoroughly in the preventive, social and mental hygiene aspects of nursing.

The basic professional curriculum leading to a baccalaureate degree would probably require four to five years. The service given by learners in all curricula would be only incidental, the exper-

ience being chosen entirely for its educational value.

There was referred to the National Nursing Planning Committee by the National Nursing Council the urgency of the need for definitions of "professional" and of "vocational" nursing and the preparation and functions of "professional nurses" and of "vocational nurses".

Use of Red Cross Volunteer Nurses' Aides in the Post-War Period: The following principles relative to the use of Red Cross Volunteer Nurses' Aides in the post-war period were given approval by the Council:

- 1. That there will be in peace time a place for Volunteer Nurses' Aides in hospitals and clinics and that such a place can best be filled by aides selected and trained by the Red Cross on the basis of substantially the same national standards as now prevail.
- 2. That hospitals should in peace time assist in the training of Red Cross Volunteer Nurses' Aides as an educational respon ibility to the community for in addition to filling a need in the hospitals and being prepared to serve in case of disaster or epidemic these trained volunteers will be invaluable to interpret the hospitals to the community.

"U.S.S. Higbee"

For the first time in history the United States Navy has placed in commission a vessel named in honor of a Navy nurse. The ship was christened in honour of Canadianborn Lenah Sutcliffe Higbee, second superintendent of the U.S. Navy Nurse Corps (1911-1922), one of four women to receive the Navy Cross and the only woman to receive it during her life-time. A battle flag was presented to the U.S.S. Highee by Miss Stella Goostray, chairman of the National Nursing Council for War Service in the United States. Mrs. Higbee was born in Chatham, New Brunswick, in 1874. She graduated from the New York Post-Graduate Hospital in 1899 and joined the Navy Nurse Corps in 1908. She retired from service in 1922 and died in 1941.

Mental Defectives

Sterilization of mental defectives should be given careful consideration, it was stated in the report of the Saskatchewan Health Services Survey Commission which was released recently.

"Much experience has been gained in this field during the last fifty years in America and Europe", the report said. "One should not be deterred by the fact that Nazi Germany has practised sterilization in a brutal and wholesale manner, but should study the results obtained in such countries as the Scandinavian countries, Switzerland, and some of the American States where sterilization has been practised humanely and cautiously with good results".

-Health News Service.

Postwar Planning Activities

Contributed by

POSTWAR PLANNING COMMITTEE OF THE CANADIAN NURSES ASSOCIATION

Opportunities in Nursing Service

With the appearance of prospects of early peace, we sense a return of the apprehension concerning future, now become immediate, opportunities in nursing. Will there be work for all registered nurses in Canada? To help quiet your apprehension, the Committee on Postwar Planning is pleased to present this brief outline of the nursing service opportunities now existing in Canada and a forecast of requirements for the not-too-distant future. Though we be accused of uttering a platitude, we feel that during the war years a definite restlessness of spirit has taken possession of our people. A great many feel unsettled, dissatisfied with their present niche. Especially has this fever for change, for new things and new excitements infected "the younger set". Our young nurses belong to this "younger set", and like all others of their group they are loathe to "settle". They feel that there is so much to be done, so many opportunities awaiting the graduate, and their young minds are quite confused. This state of mind has resulted in an almost constant fluctuation of hospital general duty personnel - usually the first position open to the new graduate. Having just completed three years in hospital service she feels an urge to "do something beside bedside nursing" something more exciting, something to her, more important. The tragedy of this situation lies not so much in the fact that these nurses are overlooking a most valuable period of their career - the period when their three years "learn-

ing" is about to be consolidated on a really skilled professional level -- but in the fact that the patients, those for whose sake presumably they took up the nursing art, are frequently being left unattended in our hospital wards. Granting the importance and attraction of the other fields of nursing, the paramount need today is for more bedside nursing. The general hospitals need nurses in increasing numbers to care for patients with medical and surgical conditions. In the wake of the war, we find a much greater demand for nurses skilled in the care of orthopedic and psychiatric patients. Large numbers of nursing personnel proficient in these specialties are needed to assist in the rehabilitation of these patients.

We feel that we cannot stress too fully or too often the importance of bed-side nursing in the total nursing picture. Can we as a professional group deny the too frequently heard accusation that nurses nowadays seem to be doing everything but nursing the patient?

We understand that the Department of Veterans Affairs is developing an extensive hospitalization plan which will require a large number of nurses for staff purposes. This opportunity to continue to nurse the wounded veteran may have a special appeal for the nursing sister who has had the privilege of sharing front-line experiences with the combatant.

With the ever-increasing popularity and spread of prepaid hospitalization plans comes an increase in demand for nursing services which in turn has creat-

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ed a demand for nurses which is at present being unmet.

With the present and anticipated continued shortage of internes and house physicians in our hospitals, many duties formerly carried entirely by them are being delegated to the nursing staff. Nurses have already been required to assume responsibility for laboratory and x-ray work, giving intravenous injections, and numerous other such tasks, in order that the day-by-day business of nursing the patient may proceed.

Tuberculosis sanatoria and psychiatric hospitals present a vast field for nursing service. We cannot begin to fill the nursing needs of these two special types of hospitals in Canada at the present time. Opportunities for utilizing special training in these branches are legion. In an early issue of the *Journal* will appear the names of the hospitals offering graduate training in these specialties.

The Victorian Order of Nurses offers wide opportunities for those interested in bedside nursing in the home, with the added interest of the various activities included in a general public health nursing program. Public health nursing positions are literally going begging for the want of nurses. It is no exaggeration to say that a thousand public health nurses are needed right now in Canada. Provincial and city departments of health have positive plans for extension of health services which are being delayed only because personnel, both medical and nursing, is unavailable. Industrial nursing is practically a virgin field in Canadian industries. War industries have stimulated more extensive health services in many plants, which it is hoped will be maintained in peace-time.

These are only the highlights of opportunities open to our nurses in our homes and hospitals. Further opportunities will be noted from time to time on this page of the Journal with the development of a placement service bureau (that is, employment bureau) in each province. It should be increasingly easier to obtain special information concerning positions available in all types of nursing service. Write to your Provincial Secretary, or the Superintendent of the hospital in which you wish to work, or to the Secretary of the Committee on Postwar Planning, National Office, Canadian Nurses Association, stating your special nursing interest, preparation, experience, etc. Thus we will know where you are and what you want to do and then the requests for nurses with your experience, preparation and capabilities can be filled.

What Local Associations Can Do to Step up

Student Nurse Recruitment

E. A. ELECTA MACLENNAN

The most effective method of recruiting — for nursing, as for anything else — is personal contact. Local associations are in a better position than are the Provincial Associations or the Na-

tional Association to employ this most effective of all recruitment methods. This does not mean that members of local associations should conduct a houseto-house canvass! But they can make the need for student nurse recruits a matter of *personal* concern to the members of their community.

One of the obvious methods of conveying information to groups within the community is through addressing them at their meetings - Young People's meetings, meetings of women's organizations and of men's service clubs. Copies of a Speakers' Handbook, especially prepared for the use of nurses and student nurses, are available on request from the national or from your provincial association. An easy way of giving information in an interesting manner is through panel discussion. Several voices in discussion are more attention-holding than one voice, especially if the several voices are of people known to the audience. The national association has available scripts using student nurses and high school students. These scripts have been prepared for radio, but they are equally suitable for use in panel discussion.

If there is a radio station in your community, you might be able to get some free radio time for the presentation of one of these scripts over the air. If you obtain copies of the scripts and take them to the station manager, he will be able to see exactly what you propose to do, and if he is community-minded, as most station managers are, he is likely to be very co-operative. The national association has in preparation 15-minute radio plays dealing, in an entertaining manner, with the life of a class of student nurses. These plays are being recorded, and recordings will be available to radio stations wishing to use one, several or the complete series (about ten) of the plays. If you are interested in these, write the national office, and they will advise you when recordings are available.

You can usually obtain excellent cooperation from your local newspaper. Releases are mailed to newspapers by provincial and national offices, but, in addition, you might interest your town paper in doing a feature article on the local situation. As an example — the Montreal Herald, at the time of writing, is preparing a feature on nursing to tell, largely in picture form, the story of the life of a student nurse and to give an indication of the work she may do as a graduate nurse. A similar article, with photographs taken at a local hospital school of nursing, would have great interest for any newspaper's local readership.

Any of these student recruitment efforts — talks, panel discussions, radio programs, newspaper features - might very appropriately be timed for Hospital Week. Something that has been tried and found very successful as a Hospital Week feature is the visiting of the local hospital by girls from high school graduating classes. If your local hospital has a school of nursing, you might arrange to have the student nurses entertain the high school girls at tea and conduct them through the residence and hospital wards. Even if your local hospital has no school of nursing, you might arrange to have a high school group visit the hospital to get some indication of the work of the hospital staff nurse and to arouse interest in nursing as a profession.

The problem of making adequate nursing care available to all who may require it is the problem of all members of the nursing profession. Anything your local association does to encourage student recruitment helps to solve this problem both for the present and the future.

The national office, as you may know, employs publicity counsel, through whom the material above referred to has been prepared, and local associations are invited to take advantage of services and material thus made available in planning their own student recruitment programs.

Counting up the Costs

War is an extravagantly costly business. For the past five and a half years we have been hearing of expenditures so vast as to be almost astronomical. Millions for planes, millions for ships, for ammunition, for uniforms, for food. We get a bit bored when the figures become so large — we can't quite imagine so much money. Perhaps if we think of expenditures in terms of the things we, as nurses, know best - hospital equipment, dressings, drugs — we will get a clearer picture of why it is so important that we keep right on buying Victory Bonds. Some of these data were given in the November Journal but the figures bear repetition: Sufficient penicillin to treat one major case, \$50; one wall plate for muscle and nerve testing, \$100; ultra violet quartz lamp, \$250; emergency operating room light for use in case of power line failure during an operation, \$300; combination set of hospital sterilizers, \$1000; high-pressure steam disinfecter for sterilizing blankets and mattresses, \$2000; complete major x-ray unit, \$5000.

Those are just a few of the more costly items you say. Alright, no hospital is complete without beds. It takes \$15,-000 to supply a thousand of them, complete with mattresses. Dressings by the thousands must be available. One hundred thousand of them cost \$10,000. Adhesive plaster is such an essential commodity for a wide variety of purposes. Thousands of yards of it must be ready for use. When we realize that one fifty dollar Victory Bond will furnish only two thousand vards of two-inch adhesive, we can see why so many individuals must assist in this problem of financing the war by buying as many Bonds as their means will allow.

How can the nurses of Canada assist in making the Eighth Victory Loan drive an outstanding success? First, by their individual purchases. If each nurse



Canadian Army Overseas Photo

Underground hospital in Holland.

bought only one fifty dollar Bond, it would represent a very large amount of money since there are over twenty thousand active, practising nurses. Second, by sponsoring the purchase of Bonds through their nursing associations ranging from the smallest local chapter to the large parent body. Such investments will not only bring in a tidy sum in interest to the association but will also be useful as the nucleus for post-war organization activities which may be planned. Alumnae associations might use their

purchases toward the setting-up of scholarship funds.

Finally, the nurses may call the attention of their friends to the rapidly increasing demand for hospitals and equipment to care for the steady stream of wounded men. The termination of the war in Europe will not bring the need for all of these facilities to an end. Let each of us be sure that no care shall be wanting because we have failed. In this spirit, the Eighth Victory Loan will be as successful as its predecessors.

R.N.A.P.Q. Reaches its Silver Jubilee

On February 14, 1920, "an Act to incorporate the Association of Registered Nurses of the Province of Quebec" was assented to by the Lieut. Governor of the Province, thereby creating the only bilingual professional nurses association in North America and the second in the world, our counterpart being the South African Nursing Association where English and Dutch are the official languages.

Last December a special meeting of the Committee of Management was held to which were invited all former presidents of the Association and others who have contributed outstanding service to the Development of our Association. Plans were drawn up for a suitable celebration of our twenty-fifth anniversary.

Realizing that any plans made in advance would be conditioned by the changing world scene, it was unanimously decided that the actual birthday (Feb. 14, 1945) would pass unnoticed and that special features would be included in the annual meeting. It is planned, therefore, that our Silver Jubilee will be celebrated on May 28, 29, 30, beginning with church services on the 27th, our fourth National Memorial and Rededication Service to be held in St. George's Church, Montreal, at 7 p.m. and 9.30 a.m. in the Chapel of old Eglise Bonsecours.

On Monday, the 28th sessions will be held in the afternoon and evening in the Windsor Hotel. These will be bilingual and will include the president's address, and reception and discussion of reports covering our many activities. On Tuesday, sessions in English and French will be conducted separately. Program plans for the afternoon are as follows: English session: Gertrude Hall and Rae Chittick will be the speakers, their topics being: "Two Types of Nurses" and "The Role of the Nurse in Canada's Rehabilitation Program". French session: Dr. Edouard Desjardins, Dr. M. C. E. Grignon, and Rev. André M. Guillemette will present: "Ce que le public attend de nous"; "Les glandes endocrines et la personnalité"; and "Techniques modernes pour la Protection de l'Enfance".

In the evening there will be a "Forum on Current Events as related to Canadian Nursing" conducted separately in adjoining halls in each language. The topics will be "Legislation" by E. Flanagan; "Labour Relations" by E. Beith and E. Rocque; "Postwar Planning" by M. Lindeburgh and J. Trudel. Discussion is to be lead by F. Munroe, G. Hall, R. Chittick, M. Kerr. E. Johns, E. MacLennan. Rvde Soeur Lefebvre, M. Roy, M. Beaumier, M. Taschereau, J. Lamothe, E. Cantin, A. Robert, A. Martineau, A. Albert, and E. Gauvin. On Wednesday afternoon, the forum of the previous evening will be repeated at Hotel-Dieu for the sisters.

A banquet at 8 o'clock in the Windsor Hotel will bring the meeting to a close. At this time we anticipate including among our guests the members of the Executive Committee, C.N.A., whose meeting, will open in Montreal the following day.

E. FRANCES UPTON

Executive Secretary and Registrar.

Saskatchewan Nurse Instructors Hold an Institute

GRACE GILES

"Wouldn't it be a help to us inexperienced instructors if we could all get together and talk over our problems and share our ideas", said a bright young instructor in one of our nursing schools. And that was how it all started. Miss K. W. Ellis, adviser to schools of nursing, discussed the proposal in the schools as she visited; so did the travelling instructor. Our president, Miss M. Diedrichs, and the Council members felt it would be a very worthwhile project for the Saskatchewan Registered Nurses' Association to sponsor. Everywhere there was an enthusiastic response. The instructors welcomed the thought of a pause in their heavy winter program when they might drop the routine for a few days and find new inspiration for the months ahead. Busy administrators willingly agreed to make the necessary arrangements. They realized, they said, that it was more often the superintendent of nurses than the instructor who was able to attend the provincial convention, and that there are many subjects directly related to teaching which there is never time to bring up at an annual meeting. So with the cooperation of the superintendents of nurses and, in many cases, financially assisted by generous donations from the hospital boards, the instructors from all the ten hospital schools of nursing in Saskatchewan met in Saskatoon for the first Institute for nurse instructors to he held in Saskatchewan. Miss Ellis, director of nursing, represented the University School of Nursing.

It was decided to hold the institute before the spring preliminary classes were admitted. Knowing that the instructors had little time for special preparation, the program was planned with a view to having a large part of the 'inspiration' come from outside the group. However, one or more nurses from each hospital came prepared to contribute to topics in which they could help one another better than could someone from another profession. Another guiding principle in planning the program was to try not to give material which the nurses had already had in post-graduate courses. All the instructors had had at least one year of post-graduate work in a university nursing school, and the following universities were represented by the group: McGill, Toronto, British Columbia, Manitoba, Alberta and St. Louis.

The spirit of co-operation displayed by nurses and those in other professions, who were asked to participate in the project, was a great satisfaction. One young lady, a director of a teen-age centre, said, "I will be glad to try to give some suggestions for planned recreation for student nurses. I have just come out of hospital myself, and I like nurses."

The superintendents of nurses in the two hospital schools of nursing in Saskatoon graciously arranged for the meetings to be held in their classrooms. There were visits to various departments in both hospitals too. One meeting was held in the University of Saskatchewan. At the City Hospital a most interesting demonstration of equipment and techniques on a children's ward had been prepared, while, in the polio clinic at St. Paul's Hospital, a demonstration of the "Kenny hot pack" was given. Displays of artistic posters which had been prepared in connection with history of nursing, professional adjustments and personal hygiene, furnished new ideas. One of the head nurses contributed some of her material for clinical teaching. This included an outline of her program and an indexed box with information on new drugs.

Several book publishers very kindly

sent books for the instructors to look over, and these proved a real centre of interest. A number of films loaned by the Audio-Visual Branch, Department of Education, were greatly appreciated. One of these entitled, "Nursing", is being used in vocational guidance work in the province. Information on sources of films suitable for nursing schools was given during the institute. A number of schools have their own movie projectors.

When arrangements for the institute were being made, the instructors were invited to send in questions in advance which they would like to have discussed. These were all combined and sent to each school for consideration before the meeting. Several lively discussions arose out of the "Question Box". Somebody said, "Should nurses' marks be posted?" Most instructors thought they should be. The objection was raised that it tended to discourage the poor student. So it was suggested that one might post the results as grades, A. B. C. D. etc., and record the actual marks in the records. Then there were the "New Ideas and the Time Savers". Both of these proved very popular. One instructor arranges a reserve shelf in the library whenever she gives a special assignment. On it go the books and other references which have been given. It saves precious minutes for the students. Making the technique of intravenous injection more realistic, by a piece of fine rubber tubing attached by adhesive to the arm and forearm of the doll, and extending up under the shoulder and into a bottle concealed at the head of the mattress, was another suggestion. How to use old books for illustrative material to use in the lantern was shown by a young nurse-teacher fresh from her university post-graduate course. One very experienced instructor described how she had secured the necessary equipment for a bacteriology laboratory at little expense, and explained what interesting cultures could be obtained from an infusion of hay. She uses washings from grapes to demonstrate yeast cells.

Space forbids mention of any further suggestions but you can see how helpful the discussions proved to be.

A symposium on skin demonstrated the correlation of various subjects, and included the anatomy and physiology of skin from a functional viewpoint, drugs and solutions as they relate to the skin, and bacteriology in relation to the skin. A talk on "Common Diseases of the Skin" was given by a skin specialist, and the symposium ended with a demonstration dressing of a skin lesion. The group listened with much interest and pleasure to a very helpful talk "On Teaching Pharmacology", especially when the speaker, with a twinkle in her eye, made such a point as warning her fellow instructors not to try to cram in too many drugs or they could expect their students to show serious symptoms of overdosage. Ward teaching held everyone's attention for two periods — one when a group of nurses, successfully dramatized a nursing clinic, and again, when a supervisor in charge of a children's ward outlined her plan of clinical teaching based on the eight-weeks' period the students are in her department. Another profitable hour was spent in learning how to make the nursing school libraries more valuable to students. This was contributed by a librarian from the Saskatoon public library.

There were three splendid lectures by Dr. S. R. Laycock of the College of Education, University of Saskatchewan. After Dr. Laycock's talk on some of the hazards in classroom teaching, one of the instructors, remarked, "Never again will I greet my class with - Today we're going to study digitalis. Instead, I'll begin — How is Mr. Smith, up on ward B, the one who is receiving digitalis I mean"? Dr. Laycock made us all resolve to do better teaching. Equally stimulating was Dr. D. M. Baltzan's lecture on psychological medicine, illustrated in a most original manner. Having Dr. Baltzan with us was of special interest because his book, 'Internal

Medicine for Nurses" will shortly be off the press and is to be used by a number of our schools of nursing as a textbook.

Instructors also need help with extracurricular programs, and the following topics proved both refreshing and stimulating, "Developing a Taste in Reading", "Interior Decorating", "Flower Arrangements", "Nurses must have a Little Fun". There were extracurricular activities at the institute too — a luncheon party at the Bessborough Hotel, afternoon tea each day, and a specially delightful formal tea on the last afternoon which was given jointly by the two hospitals.

During the week of the institute special efforts to interest the public in nursing and its possibilities as a profession were made. A very attractive series of posters on "Opportunities in Nursing", which had been lent by the R.N.A.O.,

was displayed in a window of a large department store. A nursing 'trailer' was run at one of the local theatres, while in the lobby a figure poster of a nurse urged those who might make nursing their career to take the information which her little box contained. Considerable newspaper publicity was also given to the institute.

Was our institute worthwhile? We think so. We have all become acquainted and shared our problems — rather astonished at times to find how similar they are. We have learned much from each other, and experienced the stimulation of hearing from specialists in other fields which have a bearing on our work. Already we are making plans for next year. There were questions we could not settle because we did not have enough information, so we have to do some research before we meet again.

Repairing Old Skeletons and Manikins

Old skeletons may be repaired with plastic wood (and much patience) and may serve to tide over until replacements may be secured. The edges of chipped bone should be painted with Duco household cement, which should be allowed to harden. This acts as a filler for the plastic wood which can be applied and shaped to fit the cavity present. After drying, more cement and a little of the wood can be worked down into the crevices with a toothpick. Skeletons can thus be salvaged temporarily and correct anatomy can be taught.

Manikins can be treated much in the same way. The surface of the dried wood can be colored with crayons or paint after it has been built up to the desired height.

An incorrect bone makes learning difficult for the student, as she has no background on which to base her knowledge and supposes that every hole and cavity is natural to the bone. Completely discarded skeletons may be disarticulated and the bones repaired to make adequate specimens for classroom purposes.

It takes time, but is not costly, and in some cases may be worth the effort, since new specimens are so difficult to obtain at present.

-Davis' Nursing Survey

Royal Canadian Naval Nursing Service

A conference of Matrons was held recently at Naval Service Headquarters. This conference included Matrons from R.C.N. hospitals across Canada and Newfoundland. A Special Treatment Centre has been opened at Ste. Agathe des Monts and is staffed by R.C.N. Nursing Sisters.

N. S. F. Rutledge (Toronto General Hospital) has been appointed Acting Matron, St. John's, Newfoundland.

STUDENT NURSES PAGE

Gas Gangrene

BERNICE HALEY

Student Nurse

School of Nursing, Brantford General Hospital

Mr. B. is a small, dark, somewhat emaciated fifty-year-old Frenchman. He is married, though his wife and six children live out of the city. The patient works at a war plant and lives at a men's hostel but states that he gets home quite frequently. He is a devout Roman Catholic, is interested in sports, but likes to spend as much of his spare time as possible with his family. Many of his associates and fellow-workmen, who enquired for him, stated that the patient is an excellent workman and has a friendly, cheerful personality. He attended school until he was sixteen years of age and reached Grade X.

This man was working at the plant when a glue-pot exploded and a piece of iron struck him. He received a severe laceration on his left leg below the knee, a small puncture wound in his right leg above the knee, and a comminuted fracture of his right leg between the knee and the hip. The doctor who examined him in the first aid room advised hospitalization.

On admission to the hospital ward at noon, the patient's dye-stained, soiled clothes were removed and he was placed in a previously warmed bed. He was in a condition of shock, showing symptoms of pallor, cold, clammy perspiration, thready pulse and extreme weakness. He was given a warm drink, hot water bottles were placed around him and 500 cc. of blood plasma was started. At 2 o'clock the patient suffered a chill, the reaction temperature being 100.8. When he was sufficiently recovered from the chill, a Balkan frame was erected, a portable x-ray machine was brought to the ward, and an x-ray of the pelvis, including both femurs, showed the comminuted fracture of the right femur at about the junction of its middle and distal third. The fragments were in good position.

The puncture wound was cleansed with green soap and a sterile dressing applied. A Thomas splint with Buck's extension was placed on his right leg.

The laceration on his left leg was cleansed with green soap, the surrounding area was painted with iodine 2½ per cent, novocaine ½ per cent was injected close to the site, sulfathiazole powder was placed in the wound which then was sewn up with dermal sutures, three drains having been inserted. A dry dressing was applied. Tetanus antitoxin, 1500 units, was given, the patient's blood pressure was taken every four hours during the night and morphine sulphate, gr. ¼, was given hypodermically every four hours, if necessary.

The following day Mr. B began complaining of abdominal discomfort and had difficulty in voiding. He had

voided only small amounts since the accident. Catheterization relieved him of thirty-six ounces of urine.

Two days later laboratory studies revealed a leukocyte count of 8,300 per cu. mm. of blood with a differential count of 83 per cent neutrophils, 12 per cent lymphocytes, and 4 per cent monocytes. The concentration of hemoglobin was 65 per cent of normal; erythrocyte count was 4,150,000 per cu. mm. of blood. Blood cultures obtained from the wound on the left leg revealed chlostidium welchi and staphylococcus. A direct smear revealed a moderate number of pus cells and many gram-positive bacilli resembling cl. welchi. Bacillus welchi is a short, gram-positive, non-motile rod. In tissues, it develops a thick capsule. It is present in the intestinal tract of man and most animals. Because it forms spores, it survives outside the body and lives for a long time in fertilized soil. It is essentially a saprophytic organism which becomes pathogenic only when introduced in large numbers, when foreign bodies are present, or when there is considerable destruction of tissue, particularly muscle tissue, which offers a favourable environment for growth and toxin production. B. welchi grows readily in laboratory culture under anerobic conditions. The organisms ferment muscle sugar, cause formation of gas bubbles which, by their presence, disrupt the tissues and carry the infection farther into the body. Perfringens antitoxin, which is a gas gangrene antitoxin prepared from the blood plasma of horses, highly immunized against the toxins of bacillus welchi, was administered intramuscularly in doses of ten thousand units daily for four doses.

Gas gangrene infection is characterized by profound intoxications—abrupt rise in temperature, then high fever, rapid pulse, prostration and apprehension. Locally, there is pain in the wound, redness, swelling, bronzing of the skin and crepitation, which is due to the generation of gas by the action of

the organisms on the muscle tissue. As the bacilli grow they form gas and also a poison of enormous potency; these poisons with the gas enter the blood. Two poisons are formed, one causing blood destruction or hemolysis, the other acting locally and causing edema and necrosis. Until late in the case the blood does not contain the bacteria because of its oxygen content which inhibits the growth of anerobic micro-organisms. Probably the presence of gas in the blood explains the sudden death of many patients.

Gentle pressure on the margin of the wound usually produces a sanguinopurulent exudate in which gas bubbles may be seen. X-ray frequently demonstrates gas in the tissues, and it may be heard by stethoscope. The muscles become soft, mushy, and dark red. Neutrophilia or increase in the absolute number of neutrophilic cells in the blood is common, the normal being about 3000-7000 per cu. mm. of blood, or 60-75 per cent. When well established, the infection travels very quickly up the muscle, and up to a few years ago only surgery could have saved life, and this only if the case were seen early. Backache, headache and the formation of vesicles on the skin near the wound are characteristic of a well-established infection.

Mr. B was a typical case. His temperature rose within twelve hours from 99 to 101.2 degrees. His pulse ranged well over the rate of 90, at times rising above 100. The patient looked pale, and was very worried regarding his condition, calling himself a "sick man" and showing great apprehension. At nights, he would groan loudly with the pain in his legs. The wound appeared inflamed, while sanguino-purulent exudate containing gas bubbles oozed on pressure.

Urinalysis reports showed a trace of albumin and the presence of blood cells. The patient's neutrophil count was 83 per cent. Sulfadiazine gr. XV was given every four hours for twenty-seven doses, and then reduced to gr. VII every

four hours. It is not known definitely how valuable sulfa drugs are in the treatment of gas gangrene, but it is thought that they are beneficial.

The same day the administration of penicillin was begun. Penicillin is a potent, anti-bacterial substance obtained from the culture liquor of the mold penicillium notatum. It is relatively nontoxic for tissues and can be administered intravenously, intramuscularly or locally. It acts principally on gram-positive bacteria, having a bacteriostatic action. Following an injection, penicillin is rapidly excreted by the kidneys, the blood stream being practically cleared of it in from two to three hours, thus the interval between doses should not exceed three hours. Penicillin should not be used as an irrigating solution, as it must remain in contact with the infecting organism for at least six to eight hours before it exerts anti-bacterial ef-

Penicillin came to the ward in a sterile vial and was in the form of an amorphous yellowish-brown powder. The vials we used contained 100,000 Oxford units. This was dissolved in 20 cc. of distilled water, the finished solution being 5,000 units of penicillin per cc. of solution. It was prepared and stored under aseptic precautions and made freshly every day, as it is of no value after 24 to 48 hours in solution.

Mr. B received 15,000 units of penicillin every three hours for eight days, receiving 600,000 units intravenously and 460,000 units intramuscularly. He also received 40,000 units locally into the laceration on his left knee.

The dressings on the infected wound were changed every day by the doctor, and the wound was syringed out with hydrogen peroxide. Hydrogen peroxide is a liquid which is a chemical composed of equal parts of hydrogen and oxygen. It decomposes when it comes into contact with organic matter such as pus or blood. It then yields bubbles of oxygen which destroy the anerobic bacteria

with which it comes in contact. At the same time it helps to loosen membranes and pieces of dead tissues. The more pus or dead tissue present, the more oxygen will be liberated.

Mr. B was strictly isolated throughout his illness. His linen, after use, was soaked in H.T.H. 15 solution 1/5 per cent for five minutes; his silverware was soaked in sterilol 5 per cent, and his dishes were soaked in H.T.H. 15 solution 1/10 per cent for five minutes. He had a separate dressing tray, and the instruments on this were always soaked in sterilol 5 per cent for half an hour then boiled after use. The patient was kept screened continuously. The doctor thought it advisable not to move him because his right leg was in good position and the moving might move the fragments out of place.

Mr. B is now much improved. His temperature, pulse and respiration are almost normal, and he has changed from the "agitated, sickly looking man" to one of a pleasant personality with a good sense of humour.

His prognosis is good as the wound is healing nicely, infection clearing away, and the right fracture appears to be knitting satisfactorily. After a short rest at home following discharge from hospital, he will probably go back to his work "as good as new."

My health teaching consisted in pointing out to the patient the "importance of a daily bath, and regular elimination". I taught him to clean his teeth morning and evening and develop good oral hygiene, as he had marked dental caries on admission. I tried to stress the importance of a well-balanced diet, and good noon-day lunches for a working man.

This study was interesting to me because in wartime we read that gas gangrene is responsible for many deaths among the casualties. The shrapnel wounds infected from bacillus welchi which is found so commonly in the soil tends to produce gas gangrene. I was interested to read an article in the Me-

dical Digest which stated that lives threatened by gas gangrene infections may be saved if a new chemical test proves successful. This test depends on detecting in the fluid, excreted from the wound, the presence of enzymes or ferments produced by the germs which cause gas gangrene. By using an ordinary white blood cells counting pipette, with a few simple precautions, the test

can be carried out on the battlefield and the results obtained in one hour.

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Digest of Treatment, August, 1943. Medical Digest, June, 1944.

The Manitoba Student Nurses' Association

The Manitoba Student Nurses' Association, sponsored by the Manitoba Association of Registered Nurses, is the first provincial organization of its kind. It is anticipated that through fellowship of this type student nurses in the province may develop an understanding of and prepare themselves for active participation in the broader fields of professional interests following graduation.

The first meeting was held last November in Winnipeg. Representative students from eleven schools of nursing were guests of members of the Board of Directors, Manitoba Association of Registered Nurses. This meeting took the form of a buffet supper and gave everyone an opportunity to mix socially. Our convener, Miss Frances Waugh, assisted with the planning of the first meeting and will act in an advisory capacity.

Our objectives are as follows:

- 1. To set up a body recognized as the official representation of student nurses in the province on a comparative basis with other such organizations, etc.
- 2. To stimulate interest and disseminate formation about current events in the world of nursing, with particular reference to activities within the Manitoba Association of Registered Nurses, the Canadian Nurses Association, and the International Council of Nurses.

- 3. To provide a means of broadening the cultural background of student nurses that they may be more adequately prepared for the part they must play as citizens in a community.
- 4. To form a natural means of progress from the Junior Association into the Manitoba Association of Registered Nurses, when the member becomes eligible, with an appreciation of the significance of that membership.
- 5. To promote a spirit of unity, and a common bond of understanding and of mutual helpfulness in the student nurses of this province.

The first mass meeting held in December was most successful. Over one hundred students from various hospitals attended. Our guest speaker, Miss L. Pettigrew, president of the Manitoba Association of Registered Nurses, interpreted our relationship with the Manitoba Association of Registered Nurses, Canadian Nurses Association, and the International Council of Nurses, explaining the interests of these to us professionally envisioning the expansion of organized student nurses groups on a national and perhaps international scale.

We hope that we may attain our objectives in time, as a recognized Association, and through our achievements prove the value, professionally and personally, of under-graduate affiliations with the senior organizations.



Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

Maxine Bow (University of Alberta Hospial; B.Sc.N., University of Alberta) has been appointed to the Montreal staff.

Mrs. Marjorie Salter (Ottawa Civic Hospital) and Margaret Joyce (University of Ottawa School of Nursing), having completed the two months' period of orientation in Victorian Order nursing on the Toronto staff, have been posted to the York Township and Trenton staffs respectively.

Edith Horton has resigned from the Kitchener Branch to accept a position as school nurse at the Collegiate Institute, Ottawa. Madeline Firby and Bessie Julien have resigned from the York Township staff, the latter to work as a missionary in the Foreign Mis-

sion Field. Hazel Dobson has resigned from the Vancouver staff to accept a position in the Hospital for Crippled Children, Vancouver. Essie Kain, nurse-in-charge of the Porcupine Branch, has resigned to accept a position with the Ontario Provincial Department of Health.

Margaret Oulimar has been transferred from the Amherst to the Montreal staff. Jeanne Bertrand has been transferred from the Montreal staff to take charge of the Lachine Branch.

Mabel Barry (Saskatoon City Hospital) and Alyce MacKensie (Jeffery Hale's Hospital, Quebec), having completed the two months' period of orientation in Victorian Order nursing on the Montreal staff, have been posted to the Regina and Sarnia staffs' respectively.

Ontario Public Health Nursing Service

Clara Kittmer (Woodstock General Hospital and University of Western Ontario public health course) has resigned her position with the Middlesex County School Health Unit to accept the appointment of public health nurse at Paris.

Mary Murdoch (Saint John General Hospital, N.B. and University of Toronto public health course) has resigned her position at Owen Sound to accept the appointment of public health nurse at Thorold.

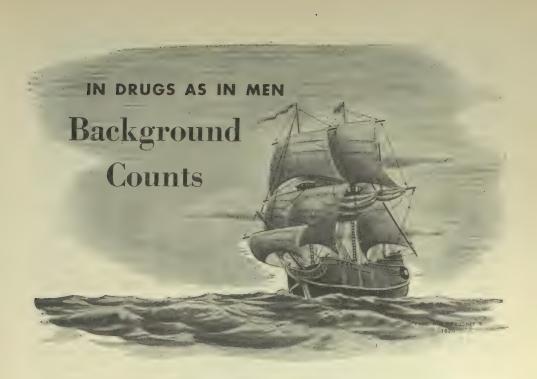
Helen Kirk (Victoria Hospital, London, and University of Western Ontario public health course) has resigned her position with Middlesex County School Health Unit to be married.

Florence Bell (Victoria Hospital, London, and University of Western Ontario public health course) has resigned her position at the Toronto East General Hospital to accept an appointment with the Middlesex County School Health Unit.

Book Reviews

Lest We Forget, edited by Annette Wellesley-Smith, in collaboration with E. L. Shaw. 28 pages. Printed by The Premier Printing Co. Pty. Ltd., 27-31 Little Bourke St., Melbourne, Australia, for the Australian Army Nursing Service. Price Two Shillings.

Commemorating the eleven courageous nurses who lost their lives in the sinking of the Australian Hospital Ship Centaur by an enemy submarine, the Australian Army Nursing Service has had this small booklet prepared to help to raise funds for the Centaur Memorial Scholarship.



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APRIL, 1945

In her editorial, Lieut.-Col. E. Lydia Shaw, Principal Matron, A.A.N.S., says:

"In order that we may perpetuate their memory in a way which will live, a fund has been established, the interest from which will provide a scholarship in postgraduate nursing, which will educate trained nurses to fill advanced teaching and executive positions".

After describing briefly the tragedy of the sinking, there are concise accounts of the work the Australian nurses have been doing in the various theatres of war including the Middle East, Colombo, Malaya, New Guinea, etc. Speaking of the work of the A.A.N.S. General Sir Thomas Blamey, G.B.E., K.C.B., C.M.G., D.S.O., E.D., Commander-in-Chief, Australian Military Forces, said: "Their great courage and their high standard of service . . . has won them the great admiration and affection of the troops they tend so selflessly".

Introduction to Microorganisms, by La-Verne Ruth Thompson, M.A., R.N. 445 pages. Published by W. B. Saunders Co., Philadelphia & London. Canadian agents: McAinsh & Co. Limited, 388 Yonge St., Toronto 1. 1st Ed. 1944. Price \$3.25.

Reviewed by Dr. L. E. Ranta, Assistant Professor, Dept. of Preventive Medicine, University of British Columbia.

From the wider atmospheres of preventive and curative medicine this book successfully extracts the essence of bacteriology and immunology. Throughout, emphasis is placed upon the effect of the life functions of microbes on animate and inanimate environments; in other words, this book offers the elementary "dynamics" of microbiology. Nurses, especially prospective public health nurses, social service workers, and home economists should find the presentation clear, useful and stimulating.

Microbiology-Instructress Thompson (Division of Nursing Education, Teachers College, Columbia University) presents her subject under five main headings: (1) "Life in Miniature" views the structure, metabolic function and reproduction of microorganisms; (2) Bac-

teria and the Environment" discusses the main chemical and physical characteristics constituting favourable and unfavourable conditions for bacterial development; (3) "Parasites and the Host" begins with the mechanisms of infection and of host resistance, and then points out the necessity for alert community, home and hospital sanitation; (4) "The Pathogens" deals both with the procedures used to isolate and identify pathogenic bacteria, and with the common pathogens in action, arranged in groups according to similarities in modes of transmission; (5) "Man Against Parasites" offers a brief history of the scientific advances in preventive medicine from ancient to modern times, from individual to community responsibility. Each of the first four units is concluded by a group of laboratory experiments designed to emphasize the conclusions to be drawn from the text. The final unit is followed by an appendix describing the use of microscopes. The book ends with an adequate index of twenty-four pages.

The text is illustrated by a few excellent line drawings by Mrs. P. C. Baker; in particular, the artist deserves commendation for the clever and attractive chapter-headpieces. It is to be hoped that post-war editions will find space for more of Mrs. Baker's work and, perhaps, for some additional subject-matter. For example, no mention is made of the encephalitides and equine encephalomyelitis, of the microbiological assay of B-group vitamins, or of the importance of preparing bacterial vaccines from fully virulent or otherwise suitable strains. Furthermore, the chapter devoted to "Organisms Transmitted by Food and Water" might be clarified by drawing a clear-cut distinction between food infections and food poisonings, and by removing all the Salmonella infections from the latter category. In this chapter the epidemiological value of bacteriophage typing of E. typhi receives no attention and staphylococcal food poisoning is erroneously attributed to enterotoxic irritation of the stomach and intestines, rather than to action upon the "vomit-centre" in the brain. The chapter on "Chemotherapy" deserves expansion and, therein, p-aminobenzoic acid,



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NURSE.....

a newer member of the vitamin B group, should not be referred to as "one of the essential amino-acids,"

The foregoing criticisms should not detract from the merits of Miss Thompson's book, rather they indicate that it both enjoys, and suffers from, freshness. It deserves a place among those textbooks on microbiology especially designed for student-nurse education.

Fevers for Nurses, by Gerald E. Breen, M.D., Ch.B., D.P.H., D.O.M.S. 206 pages. Published by E. & S. Livingstone Ltd., Edinburgh. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 2nd Ed. 1944. Price \$1.50.

This text is based upon the syllabus drawn up by the General Nursing Council for the training of student nurses. The majority of the acute communicable diseases are described in some detail in simple language. As well as outlining the distinctive features, complications and treatment of a considerable variety of these diseases, the author indicates special infections which may affect the sense organs and skin, and certain operative procedures, including tracheotomy, drainage of empyema and surpurating glands, etc. A selection of examination questions on this topic are included in the final chapter.

NEWS NOTES

ALBERTA

EDMONTON:

The annual meeting of Edmonton District 7, A.A.R.N., was held recently with Helen McArthur presiding. Election of officers for the ensuing year took place. Ida Johnson made a presentation to Elizabeth Pearston, registrar of the A.A.R.N. who has resigned and is taking up new work in Saskatchewan.

Edmonton General Hospital:

The annual banquet of the Edmonton General Hospital Alumnae Association was held recently with Mrs. R. J. Price, the president, presiding. Seated at the head table were: E. Matthewson, instructress; Mrs. E. Frazer, honorary president; Mrs. J. Loney, first vice-president; Mrs. W. McCready, second vice-president; Mrs. D. Edwards, treasurer; V. Protti, recording secretary; Mrs. J. G. Kato, corresponding secretary; the standing committee consisting of: Mrs. E. Barnes, convener, assisted by E. Bietsch, Mmes J. Hope, J. Kerr, and Miss J. Richardson.

Rev. Sr. O'Grady, superior, and Rev. Sr. Keegan, superintendent of nurses, welcomed the graduates. Miss Bietsch presided as toast mistress. The toast to the King was proposed by Mrs. Frazer and the toast to the training school was proposed by Mrs. Price. The speakers were Mrs. Price, who pres-

ented the program for 1945, and Miss Matthewson. A presentation was made to Mrs. Frazer, past president. Student nurses served and presented a short musical program.

Royal Alexandra Hospital:

The Royal Alexandra Hospital Alumnae Association held a regular meeting recently with Violet Chapman presiding. About one hundred members were present. Plans were made for a bridge with Mrs. M. H. Thompson as convener, assisted by Mmes T. R. Clarke, J. Rowlatt, and Miss M. Griffith. Dr. Graham Huckell was guest speaker and showed films of an orthopedic hospital in Scotland to which he was attached.

Scotland to which he was attached.

At a later meeting plans were made for the annual banquet in honour of the graduating class. Mrs. W. Norquay is convener, assisted by I. Johnson, A. Lysne, and A. Swift. Plans were also made for a bazaar to be held in the Fall. V. Chapman was appointed delegate to the A.A.R.N. annual meeting. Mr. Harold Weir, president of the War Services Council for Northern Alberta, was guest speaker and gave an address on "Current Events".

BRITISH COLUMBIA

CRANBROOK CHAPTER:

The annual election of officers for the Cranbrook Chapter, R.N.A.B.C., was held



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recently when Mrs. A. B. Smith's resignation as president was accepted reluctantly. Since the inauguration of the Cranbrook Chapter Mrs. Smith has given her full cooperation to its development and objectives. Our most sincere vote of thanks was extended to her as she referred her offices to Mrs. J. C. Little whom the Chapter heartily welcomes. Two additional members will be on the executive this year — a vice-president, C. Podbielancik, and a treasurer, Mrs. R. Pelton. The Chapter is happy that A. McClure has consented to retain the office of secretary, and that Mrs. C. T. Rendle will remain the convener of the program committee. Mrs. T. J. Sullivan is social convener.

The good preparation of program material has contributed effectively to the success of our meetings. A review of several nursing procedures brought about interesting discussions among both the older members and the new graduates. A lecture was given by Dr. W. O. Green on "Intravenous Injections and Blood Transfusions". The outline of the refresher course, however, will continue to form the general plans for dis-

cussion in the coming year.

NORTH VANCOUVER CHAPTER:

Mary Hallam was elected president of North Vancouver Chapter, R.N.A.B.C., at the recent annual meeting. Other officers are: honourary president, Kathleen Lee; past president, Mrs. H. A. MacDonald; vice-president, Mrs. Fred Mitchell; secretary, Frances Lang; treasurer, G. Jones; conveners: social, M. Cameron; membership, Mrs. H. R. Straw, Joan Godfrey; program, Mrs. A. P. McLean; press and publications, Mrs. R. A. McLachlan.

Vancouver General Hospital:

The Alumnae Association of the Vancouver General Hospital has just closed another successful year under the leadership of Mrs. Helen Findlay, president. In December nurses on the hospital staff, who were graduates of other hospitals, were entertained at a very enjoyable party. Money raising projects enjoyable party. Money raising projects proved very profitable, a rummage sale realizing \$300 while proceeds from a garden party and raffle amounted to over \$500. At a Fall meeting members spent the evening packing sixty-four parcels for overseas. V.G.H. graduates. During the year four subscriptions to *The Canadian Nurse* were sent to base hospitals; \$900 was contributed to the British Nurses Relief Fund, and \$100 to the Red Cross. A loan of \$200 was made from the scholarship and loan fund to enable a nurse to complete her university course. Three news-letters were sent out during the year to all V.G.H. graduates of known address. The news-letters, compiled by Dorothy May, serve to keep our graduates far and near informed of hospital and alumnae doings and have brought interesting replies from nurses in many distant corners of the globe.





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BRANDON:

At a regular meeting of the Brandon Graduate Nurses Association our guest speaker was Dr. Payne from the Ninette Sanatorium. He showed illustrated slides and gave an interesting talk on the treatment and control of tuberculosis. We had a good attendance and are now making plans for our final banquet.

NEW BRUNSWICK

MONCTON:

A monthly meeting of the Moncton Chapter, N.B.A.R.N., was held recently with A. J. MacMaster presiding. Special speaker at the meeting was Lulu Johnson who has recently returned from England where she has taught school for the past two years. She gave a delightful talk on her experiences over there. Letters of thanks for Christmas boxes received were read from several nursing sisters overseas. Refreshments were later served by the program committee.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Irene Weirs, Department of Public Health, City Hall, Fort William.

DISTRICT 1

The annual meeting of District 1, R.N. A.O., was in the form of a well-attended dinner meeting and was held recently in London, with May Jones, re-elected chairman, presiding. Reports of the various committees were read and showed a very active and fruitful year. We were delighted to have as our guests: Claribel McCorquodale, supervisor of nurses, Department of Radiology and Ontario Institute of Radiotherapy, Toronto General Hospital; Margaret Dulmage, convener of The Canadian Nurse circulation for the R.N.A.O.; Gretta Ross, second vice-president of the R.N.A.O.; Marion Stewart, president of the Alumnae Association, Toronto General Hospital; Helen B. Snow, nursing adviser for New York State for the Metropolitan Life Insurance Co.; Florence Walker, newly-appointed associate



OPERATING ROOM TECHNIC

By Anna M. O'Neill. An excellent textbook for the use of both instructor and pupil nurse. It discusses the techniques, equipment and materials for the successful performance of the more common types of operation. It is characterized by simplicity, stimulation of the right initiative, stressing of the graduate nurse's responsibility in all operations. 300 pages. 40 illustrations. \$4.40.

MICROBIOLOGY AND NURSING

By Eugene C. Piette and Jean Martin White. This text discusses not only bacteria but also ultramicroscopic viruses, pathogenic yeasts, fungi, protozoa, description of S, R, and G colonies, heterophile antigens, the use of sulfanilamide and its derivatives, etc. Questions following each chapter (about 500 in all) are a great aid to the instructor. Fifth printing. 332 pages. 30 illustrations. \$3.75.

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Chief Superintendent 114 Wellington Street, Ottawa. secretary, R.N.A.O.; Matron Crossman of Westminster Hospital, who recently transferred her membership from the Maritimes to District 1.

In accordance with the request of the C.N.A., the nurses of this District will observe May 6 as memorial day to pay tribute and honour to the nursing sisters who lost their lives in the last war and in this pres-

ent struggle.

Plans were discussed for distributing specially prepared posters throughout the District in an effort to aid recruitment for schools of nursing. Miss Dulmage spoke during the afternoon session and in her interesting talk on "The Value of The Canadian Nurse to the Nurses of Canada" emphasized and proposed suggestions for increasing circulation. Miss McCorquodale, our guest speaker for the evening, gave an interesting and educational address on the "History and Development of the X-ray" followed by her film entitled "A Nurse Looks at Radiology". This excellent film was compiled by her, and by a series of animations it illustrates what the radiologist sees by means of x-ray, as well as the various duties of the nurse in this department, and also treatment of cancer by means of radium in various ways.

Guests for the dinner and evening included Mr. Arthur Ford, chairman of the Ontario Cancer Treatment and Research Foundation and chairman of Supervisory Commission of the local Cancer Clinic, an original member of the Royal Commission for Control of Cancer in 1931 who has visited cancer clinics in America and Europe; Dr. Ivan Smith, director of the Department of Radiotherapy, London Division, Cancer Committee.

SARNIA:

The graduate nurses association of Sarnia is keenly interested in raising funds for the New Nurses Residence Fund of the Sarnia General Hospital, and \$200 was realized from an "evening coffee" recently held at the hospital.

The following graduate nurses of S.G.H. are now serving overseas: Isabel McLean, Pauline DeGraw, Pearl Bloomfield, Margaret Pateman, Daisy King. Annie Frayne is serving with the U. S. forces overseas. Inez Empy and Geraldine Lake are serving with

the armed forces in Canada.

The following are taking advanced postgraduate courses: Pearl Woods, obstetrics, Royal Victoria Hospital, Montreal; Marion South, surgery, Toronto Western Hospital; Jean Blacklock, completed course in surgery, Royal Victoria Hospital, Montreal; Mildred Davidson, teaching and supervision, University of Toronto.

LONDON:

A tea was held recently by the Alumnae Association of the Institute of Public Health, University of Western Ontario, in honour of the 1945 graduating class. Many of the nurses attending the recent refresher course were present and had an opportunity to meet the students whom they will have in the field with them in the near future.

DISTRICTS 2 AND 3

BRANTFORD:

At a recent well-attended supper meeting of the Brantford General Hospital Alumnae Association Mr. Norman Moore, director of public relations, Cockshutt Plow Co., gave an interesting talk on his trip to Alaska. At the March meeting a post-graduate scholarship was decided upon, to be given by the Alumnae. Plans were made for the Easter dance. Several interesting letters received from nursing sisters overseas have been read at the meetings.

DISTRICT 4

The 19th annual meeting of District 4, R.N.A.O., was held recently at Hamilton with the chairman, Ada Scheifele, presiding. Among the activities of the past year was the organization of a new chapter at Fort Erie with Mrs. Mabel Goldthorpe as chairman. Florence Walker, the newly-appointed associate secretary of the R.N.A.O., was welcomed to the meeting and spoke briefly. Rev. Norman Rawson gave an interesting account of his experiences while visiting the armed forces overseas.

The officers elected for the ensuing year are as follows: chairman, Ada Scheifele; first vice-chairman, Helen Brown; second vice-chairman, A. Oram; secretary-treasurer, B. Lawson; section conveners: general nursing, A. Lush; hospital and school of nursing, S. Hallman; public health, F. Gir-

van.

Hamilton General Hospital:

The Alumnae Association of the Hamilton General Hospital held a meeting recently for the purpose of meeting this year's graduating class, who numbered seventy.

DISTRICT 5

The annual meeting of District 5, R.N. A.O., recently took place in the Royal Ontario Museum, with the chairman, Pearl Morrison, presiding. A membership of 2,552 was reported for 1944, an increase of 379 over 1943. A resumé of reports of chapters, sections, and committees presented at the preceding executive meeting, was given by the secretary-treasurer, Mrs. Jean Williamson. Mrs. A. G. Seabrook, recently returned from England, spoke on "The bravery of women, as seen in the congested east-end of London during the blitz". Music was provided by students from the Toronto Western Hospital.

Preceding the general meeting, the hospital and school of nursing section, under the convenership of Helen McCallum, held a dinner meeting, when an address was given by Jeanette Merry, education officer







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The following officers were elected to serve during the coming year: chairman. C. McCorquodale; vice-chairmen, J. Wallace, H. Bennett; secretary-treasurer, Mrs. J. Williamson; section conveners: hospital and school of nursing, H. McCallum; general nursing, D. Marcellus; public health, L. Carlis; councillors, M. Winter, G. Jones, T. Green, F. Watson.

DISTRICT 8

Ottawa General Hospital:

At a recent meeting of the Alumnae Association Dr. R. E. Valin gave an interesting and instructive illustrated lecture on "Newer Trends in Colon Surgery".

The following officers were elected for 1945; honourary president, Sr. Flavie Domitille; president, Sr. Madeline of Jesus; vice-presidents, Mmes L. Dunne, E. Chasse; secretary-treasurer, H. Braceland; membership secretary, M. Kryski; councillors, Mmes H. Racine, E. Viau, Misses G. Boland, H. Chamberlain, V. Foran, K. Ryan; representatives to: registry, M. Landreville, E. Bambrick, A. Sanders; sick benefit, J. Frappier; D.C.C.A., M. O'Hare; Red Cross, Mrs. A. Powers; The Canadian Nurse, J. Stock.

Under the convenership of Mrs. B. Foley a successful raffle of a \$50 Victory Bond was held, the proceeds of which were used for the purchase of a respirator for the obstetrical department of the hospital. A timely and interesting institute on "Ward Administration" was recently conducted at the University of Ottawa School of Nursing by Sister Madeleine of Jesus, director of post-graduate courses.

QUEBEC

Montreal General Hospital:

At the annual meeting of the Alumnae Association held recently, Isabel Davies resigned from the position she has filled so ably as secretary-treasurer of the Alumnae and Mutual Benefit Association. Throughout the years Miss Davies has guided our finances and placed the association on a sound business footing. It was placed on record the appreciation felt by the members of the Alumnae Association and it was further resolved to make Miss Davies a life member in recognition of her services. Helen Morrison, school librarian, was appointed treasurer of the Alumnae and Mutual Benefit Association.

Mrs. T. C. Read (Phyllis Snow) has been appointed instructor at the Western Division. Betty Gardner and Marian Chute have joined the R.C.N. Nursing Service and

among the recent graduates who have joined the staff at the Central Division are: Ruth Willett, Janet Muff, Beulah Hillborg and Nanette Gardiner.

Friends and graduates who have worked with Jennie Webster in the past will be interested to know that she has returned to Montreal to be the guest of M. G. H. for the remainder of her life. Miss Webster receives a warm welcome, not only from her professional associates, but also from the members of the board of management of the hospital, and we are indeed pleased and proud to have Miss Webster back with us

Royal Victoria Hospital:

At a recent meeting of the Alumnae Association an interesting talk on "Some of the things that can be done for loss of hearing" was given by Dr. W. J. McNally. Wisitors at the school of nursing recently were Matron Margaret Smith and Mrs. Swallow (Helen Moore). Elsie Allder and Winnifred MacLean have left for a period of observation at the Massachusetts General Hospital. Miss Allder and Margaret Etter attended the institute on "Job Instruction" at the McGill School for Graduate Nurses.

SASKATCHEWAN

MAPLE CREEK CHAPTER:

Mrs. Charles Ferris (Clara Schnell, Maple Creek Hospital), who for the past two years has been a nursing sister in South Africa on the staff of a military hospital in Johannesburg, is to make her permanent home in South Africa.

YORKTON CHAPTER:

This Chapter reports having held a very successful meeting, in the form of a banquet, with sixty-four nurses present. Grace Giles, travelling instructor, S.R.N.A., was guest speaker, her topic being "Nurses as Citizens". Miss Giles stressed the importance of all nurses taking an active part in their Association and keeping in touch with nursing activities.





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Director of Nursing, Verdun Protestant Hospital, Box 6034, Montreal, P. Q.

WANTED

A qualified Instructress and a Surgical Supervisor are required immediately for a 120-bed hospital. Apply, stating qualifications, experience, and salary expected, to:

Superintendent, General & Marine Hospital, Owen Sound, Ont.

WANTED

An Operating Room Nurse is required for a small Cottage Hospital. Write for particulars in care of:

Box 2, The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P.Q.

WANTED

A Science and Practical Arts Instructor is required for the Victoria Hospital, Prince Albert, Saskatchewan, for September 1, 1945. The salary is \$150 per month, with full maintenance. Four weeks vacation and four weeks sick leave with pay each year. Apply, stating particulars, age, and qualifications, etc. to:

Mrs. J. S. Harry, Supt. of Nurses, Victoria Hospital, Prince Albert, Sask.

WANTED

Two Registered Nurses are required for permanent Night Duty. The salary is \$90 per month, plus full maintenance. One full night off each week. Apply to:

Superintendent, Brome-Missisquoi-Perkins Hospital, Sweetsburg, P.Q.

WANTED

An Operating Room Supervisor and a Dietitian are required for the Glace Bay General Hospital. Apply, stating qualifications, experience, and salary expected, to:

Superintendent, Glace Bay General Hospital, Glace Bay, N.S.

WANTED

A Registered Nurse, with the necessary qualifications, is required for the position of Assistant Superintendent and Instructress. Apply, stating qualifications, experience, and salary expected, to:

Superintendent, Payzant Memorial Hospital, Windsor, Nova Scotia.

WANTED

Registered Nurses are required for General Duty in a 100-bed Sanatorium. State in first letter date of graduation, experience, references, and date available for duty. Previous experience applied to following salary schedule, plus maintenance: Graduate Nurses who have had no experience — \$90 per month; one year's experience — \$95 per month; 2 or more years' experience — \$100 per month. Apply to:

Miss M. McCort, Supt. of Nurses, Niagara Peninsula Sanatorium, St. Catharines, Ont.

WANTED

A Matron is required for a 30-bed hospital in Grand'Mère which is situated about 120 miles from Montreal. Excellent living conditions. Supervisory work only. Knowledge of French preferred. For full particulars regarding salary etc. apply to:

Dr. H. S. Hooper, Laurentide Hospital, Grand'Mère, P. Q.

WANTED

An Assistant to the Superintendent of Nurses is required by the Sherbrooke Hospital. Applicants must also be able to assist with the instruction for a rapidly-explanding English School of Nursing. Position available immediately. Apply, stating qualifications, experience, and salary expected, to:

Superintendent of Nurses, Sherbrooke Hospital, Sherbrooke, P. Q.

WANTED

General Duty Nurses are urgently required for a 350-bed Tuberculosis Hospital. Forty-eight and a half hour week, with one full day off. The salary is \$100 per month, with full maintenance. Excellent living conditions. Experience unnecessary. Apply, stating age, etc., to:

Miss M. L. Buchanan, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P. Q.

WANTED

Three Graduate Nurses are required for Summer Relief, commencing June 1. Salary: \$75 per month and maintenance or \$100 and live out. Apply to:

Miss D. Parry, Supt. of Nurses, Children's Memorial Hospital, Montreal, P. Q.

WANTED

A Night Supervisor, with some X-ray experience, is required for a 40-bed new hospital. Apply, stating qualifications, to:

Superintendent, Listowel Memorial Hospital, Listowel, Ont.

WANTED

General Staff Nurses are required for the Allan Memorial Institute of Psychiatry, Royal Victoria Hospital, Montreal. Forty-eight hour week. The salary is \$100 per month, plus meals and laundry. Apply to:

Superintendent of Nurses, Royal Victoria Hospital, Montreal 2, P.Q.

APRIL. 1945

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OVOLUME 41 NUMBER 5

> MAY 1945

THE CANADIAN NURSE







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See Page 332

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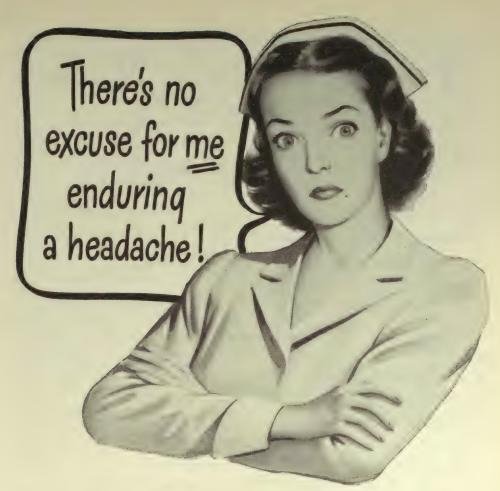


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Holmes was born in Cadiz, Spain. The ship in which his parents were travelling was captured by a French frigate and they were interned there. In 1801 the family arrived at Quebec, later moving to Montreal. Holmes was a pupil of Dr. Arnoldi, later continuing his studies abroad. In the year 1819 he returned to Canada and practised with his former teacher.

A dark man, short and slight in stature, Holmes was slightly stooped. He had a quiet, retiring manner but possessed an abundance of zeal, diligence and alertness. Christian principles characterized his life and he was known and respected for his beliefs.

Much of his free time was devoted to the study of the natural sciences. His extensive collection of the plants of Canada he presented to the Redpath Museum of McGill University. The library of McGill also benefited by his energies and he contributed, in no small measure, to building its collection of books.

Holmes was one of the first physicians in charge of the Montreal General Hospital and a member of its medical board. He was also active in all professional associations and for three years was president of the College of Physicians and Surgeons of Lower Canada.

On October 9th, 1860, Andrew Holmes passed away suddenly. The Holmes Gold Medal awarded for the highest aggregate of marks obtained in the medical course was established in his honour in 1865. The ambition of Andrew Holmes to elevate the practice of medicine in Canada, still further encourages William R. Warner & Company to maintain their policy of Therapeutic Exactness . . . Pharmaceutical Excellence . . . One price and one discount to all.



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Reader's Guide

For many years it has been the policy to have the president of the Canadian Nurses Association be the guest editor and, through her editorial, send greetings to all of the nurses in Canada. It seemed to us that, since the C.N.A. is a federation of the nine provincial associations, it would contribute considerably to the general understanding the nurses in one part of our country would have of the hopes and aspirations, the plans and problems of other parts, if each of the provincial presidents would in turn act as guest editors. To our delight, there was unanimous agreement with this plan, all feeling it was a progressive and democratic step. We have very much pleasure, therefore, in introducing the first of our provincial presidents, Eileen Flanagan, who guides the destiny of the Registered Nurses Association of the Province of Quebec. Miss Flanagan was chosen to initiate these editorials since Quebec is this month celebrating its Silver Anniversary.

A native of Quebec, Miss Flanagan, "Flin" to her friends, received her B.A. from McGill University and graduated in 1923 from the Royal Victoria Hospital, Montreal. Later, she took her diploma in teaching and supervision at the McGill School for Graduate Nurses, and had a year as an exchange nurse studying in British hospitals. Today she is supervisor of the Neurological Institute in Montreal.

Last winter the nurses of District 8, R.N.A.O., held a refresher course in Ottawa dealing with problems of obstetrical care. Dr. William J. Stevens presented one of the papers and we are happy to bring it to our readers in this issue. Kate McIlraith, who participated in this same course, is supervisor of the Victorian Order of Nurses in Ottawa. Though not part of the refresher, the points outlined in the article by Frieda Allum and Pauline McKendry seemed to fit so aptly into this discussion, we would refer you to their description of the prenatal clinic connected with the Royal Victoria Hospital in Montreal.

Mrs. Lois A. Grundy, who is supervisor of nurses, Industrial Health Division, Wartime Shipbuilding Limited, Vancouver, has given us a very interesting account of the routine duties carried on by her staff. During the time when the demand for ships was so great, thousands of older men and hundreds of women who had never before been employed in such strenuous work were inducted into the industry. How these employees were cared for by the Health Division makes not only interesting reading but sets a pattern for this type of service.

Throughout the war years, thousands of persons in Canada have taken courses in first aid to the injured. While our people have been training against a possible emergency, our colleagues in Britain have been experiencing incidents by the hundreds. One of the most important factors in adequate first aid care concerns the treatment of shock. New and different procedures for the care of patients in shock have been evolved and we are indebted to Miss K. F. Armstrong, editor of the Nursing Times, for permission to reprint her clear analysis of the two reports which have been published on this topic.

The series of articles on supervision in public health nursing which Mildred I. Walker has written is concluded in this issue. It has entailed a tremendous amount of work for a busy teacher. As Miss Walker said when she sent in the last article, "Thank God for Sundays!" The series merits close study both by executives and by staff nurses.

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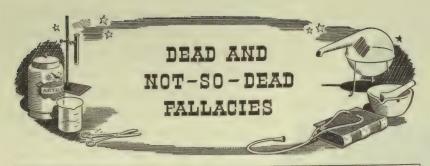


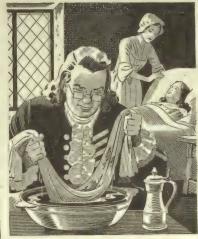




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MAY, 1945

ANTISEPSIS

The testimony of the medical press

The first paper on 'Dettol' was published in 1933.4 It dealt with only one property of this new antiseptic - its bactericidal power against hæmolytic streptococci; and only one application of this property - the prevention of puerperal infections. In this paper, 'Dettol', on the basis of an investigation at London's great maternity hospital, Queen Charlotte's, was described as more effective than any antiseptic hitherto used in obstetric practice. Within a few months of its adoption as the routine antiseptic, the incidence of maternal infections had fallen by over 50 per cent.

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Brit. med. J., 1933, 2, 723.

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(1) Am. J. Obst. & Gyn., 35:839, 1938. (2) West. J. Surg., Obst. & Gyn., 51:150, 1943. (3) Clin. Med. & Surg., 46:327, 1939. (4) Med. Rec., 155:316, 1942.

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Photo U S.A

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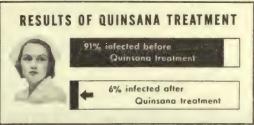
Look for symptoms of Athlete's Foot chronic peeling between toes, cracks, soggy skin, itching.

EVERY NURSE must keep her feet in most perfect condition to keep working and marching to victory. But Athlete's Foot is a real threat, as surveys show it infects 7 out of 10 adults-including nurses—sometime during the year. And the disease rages at its worst in the presence of heat and perspiration during summer! Fortunately, a new fungicidal powder—Mennen Quinsana—is scoring great suc-

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MAY, 1945



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tive freedom from irritating qualities and prolonged antiseptic action—can be yours. Abbott Laboratories Ltd., Montreal.

*In an impartial study of fifteen antiseptic agents on the oral mucosa; Tincture Metaphen was found to reduce bacterial count 95 to 100% within five minutes; to cause only slight irritation in a few cases, none in the others; and to have, in substantial excess over any other antiseptic tested, a two-hour duration of action.

Meyer, E., and Arnold, L. (1938) Amer.

Jour. Digest. Dis., 5:418.

Tincture Metaphen 1:200

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CANADIAN

N NURSE

A MONTHLY JOUR NAL FOR THE NURSES OF CANADA PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-ONE

NUMBER FIVE

MAY 1945

Two Inspirations

A Canadian novelist has just published a notable contribution to our understanding of life in this our Province of Quebec, in a book called "The Two Solitudes". We might call this short essay "Two Inspirations".

This past year I spent a few days in a very old hospital, situated high on the banks of the beautiful Saguenay River. It faces up the river and, because of this, also faces the gorgeous sunsets seen in this part of Quebec. The Sisters, whose responsibility this hospital is, were delightful hostesses, garbed in their old world habits, moving about in a quiet serene way, and showing their eager desire to know what nurses did who were out in the world, and what they could do to make their own beloved "Hotel Dieu" as perfect as possible.

I came away wondering whether we, who were out in the world, full of the knowledge of modern nursing educational methods, fully appreciated the contribution and the value of having in our midst and permeating our profession, this strong force of vocational devotion to duty. Two days later I was present at the graduation exercises of a large class of young lay nurses in an old



Rice, Montreal

EILEEN FLANAGAN



established training school famous for the forceful personality of its founder. Here one saw the other side of our heritage in this Province — the English lay nurse, imbued, too, with a sense of vocation, but a little farther away, a little more exposed to the worldly demands of the profession. I thought of the two streams flowing together, making between them the "guardians of the sick", and the bearers of the flag of Public Health.

Situations which are different, which are out of the ordinary, which require especial attention to make them work are always interesting and challenging since they call for ingenuity, forbearance, imagination and flexibility. We in the Province of Quebec are always conscious of the "out of the ordinary aspect" of our duties and privileges. The fact that we have two languages to work with, two sets of racial characteristics to balance, of necessity makes for diversity of expression, and a wider range of ideas and thought.

Since the great majority of our training schools are administered by the Sisters of Religious Orders, we have the older strong religious vocational impulse added to the modern educational methods and outlook, and if we have the will and the vision we have the opportunity to be saved from the perhaps too materialistic and mundane influences which affect those less favourably situated.

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We know that very powerful searchlights are focussed on nurses and nursing at this very moment, and we know that while we draw considerable commendation, we also draw a fair amount of criticism. Actually it is because so much is expected of the profession, because the public conjure up a combination of a "Saint", a "Nightingale", a highly trained technician, and a beautiful lady, that unfortunately they are sometimes sadly disappointed.

The wonder is that there are so many who do satisfy most of these requirements! With the great examples of leaders of two nationalities, two languages, two branches of religion, and two ways of life to inspire us, we in this Province should be able to produce the ideal nurse. This year we are celebrating the twentyfifth anniversary of organized nursing, twenty-five years of effort on the part of these leaders to assure nursing its proper place in our regime. It is a matter of great importance, both professionally and nationally, that several thousands of nurses of two languages are working together in one official organization to promote the health of the citizens and to show that it is possible to reconcile differences for the good of all.

EILEEN FLANAGAN
President
Registered Nurses Association
of the Province of Quebec

Preview

One of the knottiest problems in the school of nursing today is how to provide for experience and training in tuberculosis nursing. Our sanatoria are frantically calling for graduate staff, yet in so many instances nurses have had no actual experience with this disease and are beset with an unwarranted fear of it. How one province has solved the problem of providing undergraduate training in tuberculosis is described in detail by Ferne Trout, instructress with

the Division of Tuberculosis Control in British Columbia.

Summer camping days will soon be with us again and in many communities a search will be underway for a nurse who will be free to go to camp to care for the health and general well-being of the hordes of children. Lilian MacKinnon had a pleasant though busy time in such a place last summer. Watch for her story of her experiences.

Puerperal Care and Some Complications

WILLIAM J. STEVENS, M.D.

The puerperium begins as soon as delivery has taken place and lasts until the body has returned to normal or as near the normal state as possible. It may be divided into three periods: (1) Immediate—to cover the time the mother remains in the delivery room; (2) intermediate — the time she is confined to the hospital or home; (3) late — to extend over a year if necessary following the birth of the child.

IMMEDIATE PUERPERAL CARE:

Prophylactic, thorough antepartum care should ensure that the patient will be well able to withstand the birth. Generally speaking, ergometrin .5 mg. or some other uterine stimulant is given after complete placental separation and expulsion. The patient is covered with warmed blankets. The fundus should be held firmly but not massaged until it is well contracted down, its contents all expelled and the nurse is sure that there is no abnormal bleeding. It is much better for the patient to retain her own blood than to have to resort to transfusion.

Postpartum hemorrhage, threatening a woman's life, also prolongs her recovery. The average blood loss should not exceed 300 cc. Excessive loss, which constitutes postpartum hemorrhage, may be caused by (1) uterine atony or loss of muscular contractile power or tone, due to many pregnancies or the weakening of the muscles from a disease such as tuberculosis, cardiorenal conditions, anemia, fibroids, etc.; (2) retention of a piece of placenta, membranes or blood clots; (3) too rapid or forcible Crede expulsion of the placenta; (4) trauma from instrumental interference, manual manipulations or rupture of the uterus; (5) prolonged use or over-dose of anesthesia or analgesia; (6) distended bladder, which of course should have been completely emptied by catheter; (7) cervical laceration.

In the event of hemorrhage, immediate adequate nursing and medical treatment must be resorted to and it is here that a well-equipped hospital, with live-wire nurses, may mean the difference between life and death. The patient is covered with warmed blankets, pituitrin or ergot may be given, oxygen, stimulants; a sedative like morphine. Trendelenburg position, the uterus may be packed, followed by intravenous glucose or warm saline, pending blood transfusion, (or blood plasma to combat shock). Cervical laceration requires immediate suture. Rupture of the uterus may demand hysterectomy.

Asphyxia Neonatorum: There are two types of asphyxia: (1) livid-cyanotic or bluish; (2) pallid-pale (more serious).

Causes: Atelectasis pulmonum (if the alveoli in a part of the lung do not expand). In the initiation of respiratory movements in utero asphyxia may result by the aspiration of amniotic fluid, mucus or meconium, thus blocking the air passages. This accounts for some inexplicable deaths, at or shortly after birth, where everything seemed to be normal. Such babies, if they survive, are very likely to develop pneumonia later. Anything which interferes with the blood flow from the placenta to the baby, such as compression on the cord from the baby's head in a breech, a prolapsed cord, knots in the cord, the cord being tightly wound around the baby's head or body, or from premature placental separation. Sometimes the head is compressed too long in the vagina in a too tardy delivery resulting in pressure on

the brain; overdose of sedative drugs, like the barbiturates or morphine, and especially if too much anesthesia like ether is given after these analgesics.

Asphyxia may be anticipated in a strenuous, prolonged or abnormal labour; in cases where the fetal heart is very rapid — over 150, or very slow—below 100; where meconium is passed, except in breech presentation; where there are tumultuous movements of the fetus.

Treatments: Where anticipated, the nurse should have everything ready for resuscitation. The baby is delivered speedily and the cord tied at once. After clearing the mouth of mucus, the proper measures must be taken immediately as every second counts:

- 1. Vitamin K is given by hypodermic.
- 2. Foreign matter is removed from the air passage. The baby is held up by its feet, the throat is cleared of mucus by suction with a tracheal catheter. The buttocks are slapped gently, the baby is rubbed along its spine or sprinkled with cold water.
- 3. Mouth-to-mouth insufflation is sometimes used. The nurse places a fold of sterile gauze over the baby's mouth, the doctor then, mouth-to-mouth, blows gently into the baby's mouth to distend the lungs. In this way, mucus is forced out through the baby's nose and wiped away by the nurse. The carbon dioxide from the breath stimulates respiration. This may be repeated in conjunction with hot and cold tubs and Sylvester's method.
- 4. A mixture of pure oxygen or oxygen and carbon dioxide (7 per cent) from a cylinder may be given by inhalation or by intratracheal suction and insufflation, but the human breath is always available and saves a great deal of time. Later the baby may be put in an oxygen tent.
- 5. Hot and cold baths. Submerge the baby, all but the head, alternately in a tub of warm water at 110 degrees and

in a cold one at 70 degrees. The baby may be sprinkled with cold water while in the warm tub.

6. Sylvester method of resuscitation may be resorted to by raising the baby's arms gently above its head and then compressing them on the chest.

7. Stimulants, such as Lobeline, Coramine, Adrenalin may be given.

So long as the heart beats, never give up. Sometimes after an hour's work the infant will breathe and success here is very gratifying. You have saved a life.

THE INTERMEDIATE POSTPARTUM CARE WHILE IN HOSPITAL:

Height of the Fundus: Immediately after the baby is born, the fundus is usually on a level with the umbilicus. The uterus normally contracts and retracts down (called involution) about one finger-width per day; by the tenth day it is generally in the pelvis and is not felt above the pubes. The blood vessels are constricted by the contraction and retraction of the muscles. The nurse charts daily the height of the fundus and always makes special note if the fundus is too high (called subinvolution) which is nearly always associated with bloody lochia and is weakening to the patient.

Subinvolution is where the uterus fails to contract down to normal size after delivery. Persistence of bleeding after delivery is usually due to the fact that the proper contraction and retraction of the uterus is interfered with, either by poorly developed or weakened muscles, by the retention of placenta or membranes, by infection or by a full bladder.

In the treatment of subinvolution the nurse may massage the uterus to aid in the expulsion of anything retained and apply an icebag on the fundus. In all cases of faulty drainage raise the head of the bed — put the mother in the Fowler position so as to increase drainage. Activate the bowels, give nourishing food and a tonic, and encourage the patient to move about in

bed. Patients may be given ergot hypodermically or by mouth. Ensure no bladder distension.

Lochia is the natural bloody discharge after childbirth. It acts as a guide in the puerperium. It is discharged for from two to three weeks after delivery. For the first three or four days it is red, bloody, with decidual and epithelial cells and has a characteristic odor; for the next three or four days, it is brown and watery; for from seven to fourteen days it is pale and watery. Red lochia persists longer in elderly primipara and in women who do not nurse their babies.

There is danger ahead when the lochia stops suddenly and when it is foulodored. It may be due to subinvolution,
retained placenta or membranes, to
stenosis, closure of the external os which
may be followed by localized infection
in the uterus, called sapremia, or a generalized blood infection called septicemia. Hemorrhage is possible too. The
nurse always charts the amount and
character of the lochia, whether bloody
or purulent and if any odor is noticeable.

After-pains are rare with the first baby. These painful uterine contractions probably are due to the accumulation of blood clots and the loss or diminution of uterine contractile power or tone. They are especially common in multipara when nursing, after taking ergot, or in over-distended uteri after twins, hydramnious or protracted labours. They disappear usually after the third day. A sedative, ice bag to fundus, with massage or medicine to aid uterine contraction will relieve this discomfort.

Bladder and Catheterizing: The bladder sometimes gets greatly distended during labour. Always watch for a rounded prominence over the pubes, which is a full bladder requiring catheterizing. The patient should void soon after labour. If she does not, induce it by all known methods, such as applying a hot water bottle over the pubes, letting tap water run, pouring water, sometimes over the vulva, giving a warm

bed pan, letting patient sit up or even stand on the floor at the bedside. Catheterize every eight hours if necessary, using careful standard technique. Before delivery a full bladder greatly retards the downward descent of the head. After delivery, it may cause hemorrhage, retroversion, and great discomfort. It is the nurse's duty to report a distended bladder or failure to void. Long labours, difficult deliveries and excessive anesthesia cause fatigue which interferes with natural voiding.

Diet: First day, fluids; second day, soft diet; third day, etc., full diet where normal. There is nothing which produces an appreciable influence on either the quality or quantity of breast milk. Foods which have been recommended for this purpose have no demonstrable influence.

A daily sponge bath is given. Temperature, pulse and respirations are taken every four hours. The room should be kept bright and airy.

In normal cases, the bowels are moved with daily dosage of liquid petrolatum, an enema or a gentle purgative. Constipation, if marked, may be responsible for a rise in temperature. Where we have a repaired perineum or an episiotomy, give all treatments very carefully. An enema is preferable to a laxative, as a loose stool is liable to infect the wound. An antiseptic pitcher douche is given after each urination and bowel movement and every four hours, with careful replacement of sterile pad to vulva.

After a third degree tear (to the rectum) the bowels are rendered inactive with medicine so as to permit the torn, separated ends of the sphincter ani to grow together again and to prevent infection from feces. No catharsis or enemata are given. Diet is restricted to fluids or non-residual foods. The patient is advised not to move about too strenuously and to report any burning sensation in the perineum. Dry heat or medicated cold compresses generally relieve ordinary discomfort. After remov-

al of any sutures about the eighth day, an oil enema is given to empty the rectum.

The patient may sit up in bed the day following labour and is advised to lie on her stomach and side and to move about and exercise her legs freely in bed. Sometimes she is massaged. She usually gets out of bed on the eighth or ninth day and is discharged from the hospital on the tenth or twelfth. Backache may be the result of difficult delivery or due to the straining of the sacroiliac joints. A tight adhesive binder or a belt may be put on.

Care of the Breasts and Feeding: The mammary glands function as the result of concerted action of the lactation hormone of the anterior lobe of the pituitary gland influenced by the corpus luteum, in collaboration with amounts of estrogenic substance. The breasts contain colostrum, a vellowishwhite secretion, for the first two or three days. This acts as a laxative for the babe. After delivery the breasts and nipples are thoroughly washed with green soap and sterile water and a bland ointment on sterile gauze or wax paper is applied to the nipples. A binder is applied for comfort when the milk comes in. Before the babe is put to the breast the nipple is always cleansed with boric solution on sterile absorbent or gauze. This is repeated after feeding and the bland ointment re-applied to keep the nipples soft and free from infection. The nurse must always report any fissures in the nipples, any tenderness, redness or nodules, as immediate proper attention usually averts fissures or abscess.

The baby is usually put to breast for the first time eight hours after birth, and every eight hours for the first twenty-four hours, for three minutes each time; the second day every four hours for five minutes each time, and thereafter every four hours for ten minutes or longer, alternating from one breast to the other or to each from 6 a.m. to 10

p.m. and not during the night. Sometimes three-hourly feedings are given if the baby is small. After the milk is established, the nurse must never leave a baby at breast for more than twenty minutes at the very most, as the baby only chews the nipples causing cracks and infection.

Of course, the baby gets very little nourishment for the first two or three days but the nursing process stimulates the milk secretion and also the contraction of the uterus. Milk is generally established by the third to fifth day when the patient may have a slight temperature.

If weaning is necessary, put on a tight breast binder, apply ice bags, and restrict fluids. Magnesium sulphate may be given or the breast nay have to be pumped. Stilbestrol tablets three times daily for four days are very effective.

Visitors should be excluded always when the baby is nursing, and for the first week only immediate members of the family should be permitted to see the patient and they but for a short time. Other people may be pacified by being shown the baby. Absolutely no visitors should be allowed in the nursery at any time. Persons with colds or other infections are a special source of danger to mother and child at this time. Children are never allowed to visit as they are more apt to carry infectious diseases.

The cord generally requires no special dressing after the first. Usually it comes off within the first week. After the bath, the stump should be dressed with dry boracic powder and sterile gauze dressing. Crusts can be removed best with 95 per cent alcohol. Infection in the umbilicus might lead to the death of the baby but if the nurse exercises proper care this is unlikely. Hemorrhage may occur from a too loosely-tied cord. It must be retied and treated carefully. In cleansing the navel, the nurse must separate the folds, examine carefully and swab thoroughly with pure alcohol. Always report any navel bulging as it

might mean a tendency to rupture, needing compression.

COMPLICATIONS:

Puerperal sepsis popularly called blood-poisoning or "child bed fever" may be a very serious complication of child-bearing. Various local and general pathological conditions may occur following the invasion of the parturient canal during labour or the puerperium by pathogenic organisms. Puerperal infections must be looked upon as preventable conditions, in the production of which carelessness, error and introduction into the parturient patient of infectious material by the hands or instruments of the doctor or nurse may be responsible. In the conduct of labour the same precaution and aseptic methods should be used as are employed in the operating room. The labour and delivery rooms should be kept well ventilated. Masks of four layers of gauze should be worn over nose and mouth by all who attend in any way on the patient in labour, by the patient with a cold, and later by nurses doing perineum dressings. Masks should be changed when moist. Coughers and sneezers should be excluded from the labour and delivery rooms. Routine cultures from nose and throat should be taken. The doctor must use sterile gloves with plenty of disinfectant on his hands and gloves. He should avoid too frequent internal examinations. Strict cleanliness of the nurse's and doctor's hands and person, of the field of operation and the drapery is essential.

Causes: After delivery the raw surface in the uterus or any laceration in the vulva, vagina, or cervix may serve as a site for the entrance of bacteria. These may be naturally present (saprophytic) or may be introduced. Retention of lochia, blood clot or secundines may be predisposing factors. Stenosis or closure of the internal os due to a retroversion

may cause retention of lochia with sapremia which may go on to septicemia. The patient may infect herself with her own hands. In the third stage the doctor should allow time for placental separation. He should examine the placenta for any retained portion or membranes, and repair any perineal or cervical laceration. Keep the vulva covered with a sterile pad during the first ten days postpartum.

Symptoms: Rise of temperature, usually on the third or fourth day, with chills and sweating; pulse - usually rapid, 120 up to 140, and thready. A temperature of 100 and a pulse of 100 should be specially reported as it is indicative of threatened sepsis; the uterus may be subinvoluted and tender; the lochia may be scant and foul, may become abundant in sapremia, or scant or absent in septicemia; if infection has spread to the peritoneum there will be tenderness over the affected organ; if peritonitis is general the abdomen will be tense and distended, with vomiting, rapid pulse and dry tongue.

Treatment: Technical skill and the judgment used in carrying out obstetric procedures are very important. Complete isolation of the septic case in a separate section of the hospital is most desirable with all precautionary measures. This isolation unit should be virtually a small complete hospital within the main hospital, with individual cubicles for each case.

Nursing care consists of: rest in bed in a well-ventilated room; fresh air — septic cases should all be put out in the fresh air on balcony or roof, with plenty of sunlight; the head of the bed is raised to increase drainage; ice bag to fundus to stimulate contraction; most nourishing food is given, with stimulants such as brandy, etc., forced fluids, nutrient enemata; cold sponging is refreshing with high fever and it promotes sleep; Russian oil and enemata are preferable to cathartics; baby is taken from the breast; nurse must take all precau-

tions to avoid carrying the infection to herself or others.

Medical treatment includes: a careful examination which should be made to determine the cause or source of the infection, and treatment begun early; the sulfonamides or penicillin may be indicated; transfusions of immune blood are best, repeated if necessary; glucose intravenously or interstitially and serum given early; sedative — for sleep; ergot; iron tonic; any abscess should be opened and drained.

Prognosis depends upon the virulence of the organism, the severity of the infection and the resistance of the patient, which, of course, is low after having a baby.

Fissured nipple is due to improper antenatal care and lack of cleanliness; improper puerperal care — as failure to cleanse with boric solution before and immediately after feeding, or leaving baby to pull the nipple too long or neglect to warn patient not to touch the nipple.

Proper care generally prevents fissures. A fissured nipple is excruciatingly painful and apt to make a patient very nervous, so at the first sign of nipple trouble treat at once. When a fissure is present, nursing should be suspended; a bland ointment may be applied copiously to the nipple after cleansing with boric acid solution and drying. Sometimes the nipple is alcoholed and exposed to the air to harden it. An electric breast pump may be used every eight hours for twenty-four hours or longer giving the nipples a chance to heal.

Mastitis is generally due to infection, possibly through a fissured nipple. It is aggravated by chilling, catching cold, not dressing sufficiently warmly, congestion or insufficient emptying. The symptoms are: tenderness, caking — a lump with warm redness and pain in the breast; rise in temperature; chills; rapid pulse.

With proper early attention, breast abscess seldom develops. Report to doc-

tor immediately; the breasts should be bound with a snug breast binder and ice applied over the tenderness; Epsom salts to mother or stilbestrol aid in the absorption of milk; fluids are restricted; breasts may be emptied by breast pump; if an abscess is evident by fluctuation, it must be incised and drained at once. It takes about six weeks for this to heal.

Either melancholia (depression) or mania (excitement) may develop the first month after delivery, mostly as a result of toxemia, puerperal infection, sudden grief or shock, especially in one with a delicate mental balance. This is often an inherited tendency. In the treatment of this condition, the baby is kept away from the mother and not allowed to nurse. There is danger of the mother injuring the baby. The breast pump may have to be used; sedatives are given to quiet and induce sleep; placement in a mental hospital is often advisable; constant nursing attention is vital. She must never be left alone.

The patient usually recovers. The more acute the onset and violent the symptoms, the better the outlook. As a rule she recovers in one to six months or never. There is always a tendency to recurrence.

THE LATE PERIOD:

Prior to discharge from hospital a gentle pelvic examination is done and any abnormalities are noted. These may be rechecked and treated as required after the sixth week examination. Following childbirth it requires about three months for the return of the uterus and parturient canal to the normal pre-pregnant state.

Of 9½ days' work lost by the average Canadian wage earner in a year, nine days is lost through sickness and non-industrial accidents and one-half day through occupational accidents.

The Nurse's Part in Prenatal Care

KATE McIlraith

Carolyn Van Blarcom has stated that "The nurse's part in a program for prenatal care is to assist the doctors in carrying out the prescribed details of supervision, instruction, and care of expectant mothers, and to work toward the ideal of having every expectant mother in the land under medical care from the beginning of pregnancy".

How can this be accomplished?

A great deal has been done not only by public health nurses but by the use of literature, that is, by books, the Women's page of newspapers, and the better magazines, where splendid articles on the different phases of maternal care are printed. But the important thing to be considered about maternity care is that there are still not enough people who know what it is in all its elements and not enough people are putting into practice what they do know. This is as true of nurses as it is of doctors and laymen. Yet, if there is one field in nursing that demands a combination of knowledge, skill and common sense, it is the maternity field.

In addition to acquiring a fund of knowledge and skill the nurse should have the ability to impart information to others. To do this she needs a genuine interest in what she is teaching, and in the people she is teaching, as well as a knowledge of teaching methods and of human psychology. In other words, what she does with her equipment of theories, facts, and skill is even more important than her possession of them.

In any prenatal program the nurse has a responsibility not only to the patient but to the doctor in charge, and to the community. She owes to the doctor her loyal support and confidence. She must realize that every detail of maternity care originates in, and is guided by, the medical profession. The entire scheme

of prenatal supervision is but the interpretation and application of the doctor's orders for the health and well-being of the expectant mother.

In regard to her responsibility to the community, the magnitude of this obligation cannot be over-estimated since widespread prenatal work cannot be carried out without the whole-hearted support of nurses. The very future of our race depends upon her realization of this. For her active support and interest in this work to bear fruit, not only must she be familiar with what constitutes adequate prenatal care, but she must be imbued with a desire to convey this interest and enthusiasm, not only to her patients, but to the community at large. The nurse should have an understanding of the conditions which are destructive of life and health among mothers and babies and how adequate supervision will prevent these. She should know about the accompanying physiological changes and their meaning, the early, and even the very mildest symptoms of abnormality; how they are prevented and how to secure prompt attention when and if they appear.

Carolyn Van Blarcom states: "The thing to be burned and seared into the nurse's brain is that the ideal we are striving for, which she must help to achieve, is adequate care for each expectant mother. This means getting every expectant mother under care and then making that care so satisfactory and effective that it will save her and her baby. To reach that end we need to have complete and skilful maternity service more widely available in this country and the lay public so widely convinced of the pressing urgency of good care in all cases that such care will be demanded!"

"What we need, apparently, is not

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that the high peaks of obstetrical work shall be higher, making it possible to save a few mothers from rare complications, but that the average of the care given to all patients shall be raised. Every detail of the care and supervision of even so-called normal cases should be regarded as of such importance that it will be performed with utmost pains. Every expectant motiler should be taken seriously. This should be repeated over and over and never lost sight of. Every expectant mother should be taken seriously!"

The real test of the nurse's knowledge of maternal care is reflected in the activities and attitudes of the patient and those of the whole family. The starting point with each patient is based on what that patient knows about motherhood and her ability to absorb further knowledge. The average woman needs to know why rest, good diet, exercise and medical supervision are important to her and her baby. She needs to realize that her baby is already nine months old when he is born. She needs to be convinced that details of care which seem to be wholly unrelated to her own or her baby's welfare will actually increase their chances of life and health, and that by caring for her own health she is caring for her unborn baby.

The nurse must win the trust and confidence of her patient or patients before she can do any teaching. This can be accomplished only if the patient feels she can rely upon the nurse's ability and sincerity. The nurse's duty to the patient might be divided roughly into three parts: (a) watching or supervising; (b) teaching; (c) sustaining or giving moral support.

Let us look at the first one — watching; the nurse has an opportunity to observe the patient carefully between the doctor's consultations with the patient and report to him anything out of the ordinary that she notes. She can sift through the symptoms and give him a detailed report. Such symptoms are, for

instance, headache, which may be significant of some complication or merely that the patient has been in the habit of sleeping until late in the morning with her windows all closed; constipation or fatigue which may be in itself alarming, or may result merely from wearing improper clothing and having inadequate rest. One is reminded at this point of the lady who walked four to six miles per day until the day she went to the hospital. She did not realize that walking on city streets is much more fatiguing than walking down country lanes. After her baby was born, she told us of this tired feeling but it did not occur to her to tell her doctor of her long brisk walks. She thought it too trifling for mention although he was trying to account for the undue fatigue.

Too much emphasis cannot be placed upon the value of complete pictures of the patient both mentally and physically; depression in one who is ordinarily cheerful; a newly-developed tendency toward carelessness. These as well as the fatigue may be first symptoms of a toxemia and should not only be reported but watched carefully.

The significance of an elevation of temperature, testing the urine for albumin, watching for varicosities, the care of the nipples and breasts, the need for rest, exercise and sleep, proper nutrition and its effect on the health of the mother and baby are a few of the points carefully explained by the nurse on her visits.

The teaching can be roughly divided into: (1) Teaching the mother the importance of prenatal care — that is, adequate medical supervision and proper health habits for herself, finding out the doctor's orders and interpreting and emphasizing the importance of following them. (2) Teaching her something of what is taking place in her body, what to expect and what symptoms to report. (3) Teaching her how to prepare for her coming baby, what clothing and equipment are essential for its proper care. It should not be necessary for a

mother to give a carte blanche order to a saleslady in a baby department, whose primary object is to make sales, the more the better. (4) Teaching her the symptoms of the onset of labour, how to prepare for home delivery so that the doctor and nurse can give her skilled, efficient care with the minimum of confusion in her home or, if she is going to hospital, teaching her when to go to hospital and what to take with her.

At this time it is wise to teach her the value of having a trained person help her when she comes home from the hospital with her baby. It seems ludicrous that a new-born baby, after being given such excellent care in the hospital for the first two weeks, should suddenly be turned over to the care of a young mother who is totally unprepared. Too often, kindly but misinformed neighbours or "women" give the care. In one such case a "woman" was helping out the young mother by bathing the baby. This woman was not very well; she had just had quinsy but felt quite well enough to bathe a baby -"after all, it is not heavy" - to use her own expression.

If we ourselves are convinced of the value of breast feeding then let us remember that the groundwork is laid in the prenatal period. In the first two weeks in hospital every facility is used to get the flow of breast milk off to a good start. If this is to be maintained, let us assure the mother of adequate, understanding care at that most crucial time when she first comes home from hospital and has to fit the care of a new baby into her household regime while she is still far from strong.

The third aspect of the nurse's duty might be described as giving moral sup-

port or allaying fears. No two patients are alike, physically, emotionally, socially or financially. The attitudes, reactions and emotional difficulties of the patients are as important as their physical symptoms. Not every expectant mother looks forward with pleasure to having a baby. Some have a feeling of revulsion towards the change in their appearance, some look upon the thought of breast feeding with disgust. A common reaction to pregnancy is fear - fear of death, fear of labour, fear of marking the baby, to mention but a few. Very often these patients do not admit these feelings to their family or even to the doctor; sometimes, indeed, not even to the nurse. The nurse's attitude, her sympathy and understanding will do much to remove these difficulties.

More and more emphasis is being laid upon the tremendous part emotions play in the successful or unsuccessful termination of a pregnancy. A nurse inadequately informed or unsure of her knowledge is not much help here. The nurse must also be able to develop in the prospective father a sense of responsibility that may not have been there originally. Too often our own attitudes have helped the father continue in his belief that it is his wife alone who is expecting the baby. The nurse is in a strategic position to help both parentsto-be develop an attitude of genuine welcome to the new arrival.

To quote from Carolyn Van Blarcom again: "The nurse's part is to take hands with each patient, as she treads the long road of expectancy, pressing it warmly always, holding it firm over the rough places, and steadily giving the best she has to offer of tenderness, understanding and skill".

Preview

All of the problems associated with the care of children when they are well become greatly exaggerated when they are ill. The difficulties are further intensified when hospitalization is necessary. Linda Robertson has outlined for us some of the essential factors of the care of "Children in Hospital".

Group Teaching in the Prenatal Clinic

FRIEDA ALLUM and PAULINE McKENDRY, B.Sc.

The great importance of prenatal care has been emphasized time and again, and most women today are aware of the advantages of this care, and seek it early in pregnancy. The Royal Victoria Montreal Maternity maintains a central clinic at the hospital, and four other clinics are situated in different parts of the city. At these centres women receive this service free of charge during their term of pregnancy, and are advised to return for a complete physical and pelvic examination six weeks after delivery.

The model patient is one who registers with the clinic early in her first trimester. On her first visit, she is interviewed by the social service worker, who investigates each new case to determine the financial status of the patient, and any woman who has the means to secure the services of a private practitioner is encouraged to do so. She is then given a complete physical examination by the doctor, her urine is tested, her blood pressure taken, as well as a blood Wassermann and hemoglobin. A pelvic examination follows and pelvic measurements are recorded. The normal patient returns every four weeks during the first trimester, every three weeks during the second, and every two weeks or even weekly in the third trimester. If there are any abnormalities additional examinations are performed, in which case the patient may be requested to enter the hospital. If the hemoglobin is very low, the patient is given blood transfusions and a high iron diet.

The Prenatal Clinic is a teaching centre. First, for medical students of McGill University, and resident internes, who, under the supervision of a staff physician, examine patients and discuss with him problems which may

arise concerning each patient. Here also, post-graduate nurses and affiliated students receive part of their obstetrical training and are taught the importance of this type of service.

The clinic is primarily a teaching centre for patients. Individual teaching is difficult and rather impractical with a large attendance such as ours, so to overcome this a series of lectures and demonstrations have been arranged, and patients are invited to attend these classes which are given by a staff nurse or dietitian twice a week. A bright and attractive room has been fitted up as a class-room. Pictures selected from a portfolio of thirty-one teaching charts showing safe maternity care, which were obtained from the Maternity Centre, New York, are arranged where they may readily be seen and studied. A cheerful and informal atmosphere is secured in order to put patients at their ease. They are encouraged to discuss freely with the staff nurse their problems and worries.

During the first lecture, signs and symptoms of pregnancy are discussed, and the anatomy and physiology of the pelvis and its organs are illustrated by means of the Birth Atlas, prepared by the Maternity Centre Association of New York. The nurse instructs in personal habits, the type of clothing the patient should wear, and the food she should eat during this period of her life. The dietitian gives instruction in nutrition during pregnancy at the second class. She explains the reasons for restricting salt and protein and for taking additional milk and fluids. This class is given at two of our Settlement Clinics by a worker from the Diet Dispensary. The third lecture deals with the signs and symptoms of labour; the patient is also told about the care she will re-

PRENATAL CLINIC



Demonstration at the prenatal clinic

ceive in hospital, the value of post-partum exercises, and the need of an examination six weeks after delivery. The patients show great interest in the lecture dealing with baby care. The daily routine in the care of the infant is described and a demonstration bath given. The equipment used consists of a lifesize washable doll, bath-tub, bath tray, layettes, baby basket, and diaper pail.

The fifth lecture of the series "artificial feeding", begins by discussing the value and importance of nursing the baby. So many of the women want to be able to get back to work quickly and are, therefore, somewhat indifferent to the proposal that they feed their infants. For those who are reluctant to adopt this ideal method, a demonstration is given of the equipment which is necessary for the safe handling of prepared feedings. This includes kitchen utensils, bottle rack, bottles, jars, nipples, and rubber caps.

For those patients who are having their babies at home there is a special class to help standardize the preparation. Their homes are visited during the prenatal period to check on supplies and to make suggestions about the arrangement of the room for delivery. Only multiparas who will have a normal delivery are accepted as home cases. These patients are delivered by a medical student under the supervision of an interne. This service is inexpensive for the patient and is maintained as a source of practical experience for the medical students and the nurses in training. The mothers and babies are given morning care by our nurses for tend days following delivery.

Our aim ever since the institution of this teaching program has been to make the women more fully alive to the possibilities of improving their living habits and to impress them with the fact that good care of themselves and of their children is not an expensive, vague and impossible thing, but something which all, who are interested in the welfare of the nation, are endeavouring to secure for them—that is, a safe and happy motherhood.

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The Friedman Test

LILLIAN E. MARTIN

We have been using the Friedman test for pregnancy for the past four and a half years and have gradually worked out an apparently reliable system. As nearly as we can ascertain from our follow-up records we have better than 99 per cent average correct results.

The value of reliable animals cannot be too greatly stressed in achieving results with a high degree of accuracy. Originally, our source of supply for rabbits was very precarious and we were obliged to accept the seller's statement that the does were mature and virgin. We soon discovered that, if our results were to be depended upon, we would have to have more faith in our animals. Consequently we found a reliable person with whom we made a contract to supply us with healthy virgin does at least three months old and completely segregated eight weeks after birth, that is, the females are segregated from each other as well.

Eventually we decided that we preferred the medium-sized, short, straighthaired white animals (New Zealand), so our man raised only that type. We guaranteed to take at least twelve a month; usually we were well over the quota. In order to supply us with an approximate two hundred a year he had to produce double the amount to be sure of the required number of does. Our laboratory requirements for bucks are limited; six to eight per year are used in the preparation of our Wassermann hemolysin. While we have found the animals from this source to be very healthy we are anxious to maintain a high standard and if necessary check smears, cultures or growths for him.

To kill the animal we simply inject the ear vein with about 8 cc. of air and death is almost instantaneous. Not much of the animal is wasted; after skinning we remove the brain and process it to make the thromboplastin solution for the prothrombin tests.

Threatened with a rabbit shortage, I have anesthetized the animal and through a midline incision with a small instrument like a buttonhook (made by bending some old eye probes and dental picks) have drawn out the ovaries, examined and replaced them, then put in a couple of sutures to close the incision. In about six weeks the animal can be used again. These animals require more care and, while the method is fine in case of a shortage, we prefer one animal per test as being more sure and less time-consuming.

We keep a supply of well-washed 3 ounce wrapped bottles on hand to give to patients, with instructions. We ask them to have their evening meal as usual and whatever nourishment they are in the habit of having at bedtime, but absolutely nothing by mouth - food, fluid, drugs, etc., after midnight or until the first urine specimen is collected in our special container in the morning. The container is brought to the laboratory in the forenoon of the day collected. Specimens should be used fresh, although Mull and Underwood, add that if kept on ice the urine should be useable for one week.

The urine is checked for specific gravity and acidity, and the required amount filtered. Although most textbooks state a slightly acid reaction is more suitable, we get equally good results with either acid or alkaline. The specific gravity is a good check on concentration and if the specimen is too dilute, say 1.003, we ask for a repeat with further curtailment of fluid intake. However, some catheter specimens sent in from hospitals have a low specific gravity and we have obtained positive

results on a few with specific gravity of 1.006.

When the urine is filtered, approximately 3 to 6 cc. are put into a small syringe with a 23 G1 needle. We do not use a rabbit box but firmly swathe the animal in a sheet or large towel. One operator controls the rabbit and holds the ear to be injected close to the head, shutting off the blood flow. The ear is flipped vigorously until a marginal vein is well congested. The hairs are plucked out — to show up the vein more clearly; it may be swabbed with xylol but we try to avoid this procedure as it seems to irritate and make the animal more jumpy.

Depending on the size of the animal, 3 to 6 cc. of the specimen is slowly injected, and this is repeated the following morning. In forty-eight hours the animal is autopsied and the presence of corpora lutea and corpora hemorrhagica noted. Sometimes we find one ovary with a positive reaction, while the other is quite negative. A repeat check on a new animal, however, has always shown a definite positive.

Occasionally the rabbit has violent convulsions and dies immediately on injection. This is usually caused by lack of co-operation on the part of the patient in the matter of taking drugs, or by the specimen having become old and contaminated.

It seems pretty well confirmed that the amount of hormone in the urine during pregnancy rises abruptly from conception to its height two weeks later and remains so to within two weeks of full term, from then on rapidly diminishing so that the urine at child-birth may give a negative or doubtful result. Therefore the specimen should be obtained not before two weeks following the date of the missed period if results of the test are to be reliable.

If the patient has an abortion the secretion of hormone may continue for a variable length of time — two days to two weeks. Attached placental tissue will give a positive result even in a partial abortion, so the doctor has a better idea of the condition with which he is dealing.

A weakly positive test may be of as much value as a decided negative or positive. It may indicate a tubal or unhealthy pregnancy which may terminate in miscarriage, according to Tenney and Parker. Monthly pregnancy tests should be performed for one year after the removal of hydatidiform mole as a positive reaction longer than six weeks after evacuation usually denotes the presence of chorionic epitheliomas — to which DeLee adds "or a new pregnancy".

A Friedman test can be made on spinal fluid and seems of particular value in diagnosing hydatidiform mole and even seminoma occurring in a male with an ectopic testicle. Vesell and Goldman claim that the spinal fluid Friedman test is negative in all pregnancies, normal or complicated, and in their series it has been positive only in cases of hydatidiform or seminoma.

McCullagh and Cuylers in their series of fifteen cases of pituitary tumour, reported eight cases in which positive reactions to the Friedman tests were obtained.

The following case histories have been selected from among the patients of our clinic on whom Friedman tests have been performed, because they indicate the unusual cases in which the Friedman test may be of special diagnostic significance:

Case 1: Mr. W. M. S., age 44. There had been an increasing mass in the right testicle for two years. There was no pain and the patient thought it was related to a blow he had received in that region three years previously. His general health was excellent; Wassermann reaction negative, and Friedman urine test negative. Orchidectomy was performed and the pathological diagnosis was seminoma of the testicle. Patient is alive and well.

Case 2: Mrs. G. M., age 50. This patient

was seen on March 22, 1941. Five months earlier curettage had been done and a diagnosis of hydatidiform mole made. Curettage was repeated in February, 1941, but no evidence of the condition was discerned. About four weeks before the patient was first seen she had noticed left temporal pain. The following day spots appeared before the left eye and on the next day the patient was completely blind in this eye. Swelling about the eye started two weeks later and was still persisting. On examination the left eye revealed marked proptosis. The pupil was occluded by fibrous exudate. On March 29, 1941, a Friedman urine test was positive and enucleation of the left eye was performed. Pathological diagnosis: Degenerating carcinoma. Patient was discharged from the hospital April 4, 1941. Follow-up could not be obtained.

Case 3: Mrs. A. B. L., age 23. Last menstrual period December 1, 1941. Usual period did not recur. January 1, 1942, spotting, intermittent vaginal bleeding and lower abdominal pain occurred. Pulse jumped from 70 to over 100 on January 31, 1942. Laparotomy was performed and revealed a right ectopic pregnancy. A Friedman test (urine) was done and was positive but the symptoms necessitated operation before results of the test could be returned. Patient is alive and well.

Case 4: Mrs. J. B. T., age 37. This patient was admitted to the hospital January 16, 1940, with lower abdominal crampy pains for one month, vaginal hemorrhage for six

weeks, vomiting for one month. Patient stated that last normal menstrual period had occurred in October, 1939. A Friedman urine test was positive. On January 20 curettage was done. Pathological diagnosis on material sent to the laboratory; typical hydatidiform mole. Patient is living and well.

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Health Program of Wartime Shipbuilding Limited

Lois A. Grundy

The Allied world's need for ships became a major concern in the critical days of the war. More tonnage was being sunk than was being replaced by the output of existing yards. Construction of new yards was necessary. The time factor was paramount. The labour situation was rapidly becoming acute.

Wartime Merchants Shipping, later known as Wartime Shipbuilding, came into official existence in April, 1941. It is a Crown Company operating under the authority of the Minister of Munitions and Supply. Its job was to get ships built. Once the initial problem of getting this huge ship-building program underway, Management of Wartime Shipbuilding became concerned with the major problem of maintaining manpower supply. Production schedules were operating twenty-four hours a day and seven days a week. Labour was being

WARTIME HEALTH PROGRAM



Nurse's office, showing eye chart and pamphlet rack

drawn from men rejected by and discharged from the military services, men in their late fifties who had retired from active manual work, youths under military age and women. The majority of the employees were new to shipvard work and in addition to having to be trained in their trades also had to be educated regarding the hazards of the industry. Steps had to be taken to reduce turnover and to keep everyone fit and on the job. Unions felt that such trades as mass arc-welding, acetylene-burning and spray-painting might have health hazards which would prove injurious to the health of their members.

Wartime Shipbuilding requested the B. C. Medical Association to recommend an industrial health program that could be adapted to the Shipbuilding Industry. In 1942, the committee on Industrial Medicine of the B. C. Medical Association, after a careful study of B. C. ship-yards, found that the major yards were located in the metropolitan area of Greater Vancouver and were easily accessible to medical, hospital and ambu-

lance services. A survey of the first aid facilities, for accidents and ordinary sickness, showed that first aid stations for both men and women were conveniently located throughout the yards. First aid treatment was administered by attendants who had had special training and held Industrial first aid certificates issued by the Workmen's Compensation Board. The Committee, therefore, recommended that a full-time preventive service be established to consist of preemployment and periodic examinations, consultations for occupational and emergency illness at work, environmental supervision, sanitation, communicable disease control, general health education and, in addition, act in an advisory capacity to the first aid and safety departments.

This recommendation was accepted by Wartime Shipbuilding Limited. The personnel division which attends to shipbuilding progress, labour relations and publicity was enlarged to include two new divisions: medical and safety. A medical director, supervisor of nurses

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and a medical officer for each plant were appointed. The safety program was placed under a safety co-ordinator acting in an advisory capacity to the safety departments of the yards.

Each yard agreed to equip and maintain medical suites and to pay for the necessary nursing and clerical services. These divisions were to function under the direction of and be responsible to the medical director of Wartime Shipbuilding.

A half-time doctor is employed in yards with under twenty-five hundred employees; a full-time doctor with twenty-five hundred and over. Our nursing and clerical staff has been one nurse to approximately three thousand employees; one nurse with clerical assistance for three to four thousand and two nurses for four to five thousand; two nurses with clerical assistance for five thousand and over. One first aid attendant is employed for every five hundred employees.

The nursing staff assumes the nursing duties and the direction of the clerical staff necessary to carry out this preventive program. They establish and main-



Nurse's laboratory and work centre.

tain office routine, take all personal histories and assist the doctor. Blood samples are taken for tests for syphilis. Hemoglobin readings, urinalyses and other routine tests, such as vision, hearing and blood pressure are done. Follow-up work arising from examinations and consultations is recorded and filed for future reference. Suitable referals are made to family physicians, clinics and agencies.

From fifteen to twenty minutes is required for a physical examination. At times the number of employees to be examined was too great for the doctor and a screening method was necessary. The nurse was allowed to pass men whose medical history was clear within certain age limits and who were to be employed in certain specific jobs. Arrangements were made to recall these men at a later date for a complete physical examination.

Vitally important to this type of service is the building up and maintaining of adequate records, if statistics of any value are to be compiled. In addition to the individual history record which contains all pertinent information, a day book of all office visits, classifying the reason of the visit, the disposition of each case, the laboratory work and follow-up work is kept. A weekly report of all office visits properly classified, with disposition and synopsis, is sent to the medical director.

The physical examination is similar to insurance and life extension examinations. Pre-employment examinations are used to place the worker in jobs suited to their physical and emotional status, where they are least likely to endanger their health or cause injury to others. Periodic examinations are done at intervals to check health effects of their jobs and to find early signs of occupational illness. By these examinations and consultations, observation of individual health is maintained.

During the past two years physical examinations have been the principal

activity in the medical division. Several reasons made this necessary: (1) Over twenty thousand were already employed in the B. C. ship-yards at the time of the establishment of the medical service. The payrolls were built up in six months to over thirty thousand. There was a monthly labour turn-over of 6 to 8 per cent. (2) There was need for periodic examinations of certain trades where health hazards were likely to exist. All requests for change of occupation for health reasons had to be recommended by the yard doctor. (3) All women workers were to have an annual examination. (4) Labour within certain age brackets was frozen. Among this group were a number with work limitations. National Selective Service was required to direct this group to industries of high priority rating. Our division has been helpful to National Selective Service by classifying medical releases as follows: T1 - Totally unfit to work in ship-yards; T2 — Terminated for a specified period for medical treatment; T3 - Terminated because no suitable job was available in that yard.

The Vancouver area is well supplied with excellent public health services; we have received the fullest co-operation from all these groups. The Vancouver Metropolitan Health Committee is available for advice on many technical questions. Their well-organized public health nursing service is available for home visits. This Committee is responsible for communicable disease control and notifies us of ship-yard workers who are contacts of certain communicable diseases. These workers are given instruction regarding the signs and symptoms of the disease, the incubation period, and are required to report to the yard medical officer at stated times during this period for examination.

The Provincial Laboratory has examined over seventeen thousand blood samples for syphilis; about 1.5 per cent were positive. Well over four hundred

other tests were done which include sputum, swabs, stool and urine cultures for food handlers.

The diagnostic and treatment services of the Provincial Board of Health, Venereal Disease Control, are used. We report all positive bloods on a new industrial survey form, which includes the name of patient's family doctor and the date and time of a clinical appointment. When the patient reports either to his own doctor or to the clinic, we are advised of the diagnosis and whether the patient is in the infectious stage. If he fails to report we follow the case and make suitable arrangements.

The Provincial Division of Tuber-culosis Control provides survey, diagnostic facilities, social services and hospitalization. To date nearly twenty-two thousand chest x-rays have been taken. A survey last Spring covering most of Vancouver ship-yard workers showed that 1 per cent of those x-rayed were diagnosed as tuberculous. Only one-third of the cases were in need of active treatment; slightly more than a fifth of this number after receiving treatment have returned to work in the industry.

Industrial engineering and sanitation services are provided by the Dominion Department of Health and Welfare.

Pamphlet racks in the offices are kept well supplied with literature. A wide range of subjects, covering many aspects of adult health, are available.

All these services are available to the worker without cost; largely as a result of these facilities, the annual per capita cost of the ship-yard health service is under three dollars.

Our records show, that of the sixtyfour thousand office visits, 87 per cent returned to work following the examination or consultation with the plant doctor. An office visit requires a half to one hour of the workman's time and without such a service he would lose the greater part of a day to consult an outside doctor; thus a tremendous numher of man-hours of labor are saved. A study was made of the 13 per cent who were taken off work. These were divided into three groups and classified under thirty broad headings. The first ten reasons were listed for comparison and study as follows:

- 1. Those who were acutely ill or in need of immediate medical attention: upper respiratory infections, 22.8 per cent; old injuries and deformities, 14.2 per cent; other alimentary conditions, 7.3 per cent; eyes and vision, 7.3 per cent; ears and hearing, 6.2 per cent; dermatoses, 6.2 per cent; chest conditions other than tuberculosis, 5.2 per cent; arthritis and rheumatism, 2.7 per cent; acute infectious diseases, 2.5 per cent; general debility, fatigue, etc., 2.3 per cent. The first ten causes accounted for 76.2 per cent of this group.
- 2. Those who for medical reasons were rejected or terminated from shipyard work: old injuries and deformities, 15.6 per cent; chest conditions other than tuberculosis, 11.0 per cent; neuroses, 8.3 per cent; arthritis and rheumatism, 7.2 per cent; heart disease, 7.2 per cent; peptic ulcer, 5.9 per cent; general debility, fatigue, etc., 5.2 per cent; eyes and vision, 5.1 per cent; ears and hearing, 3.7 per cent; upper respiratory infections, 3.6 per cent. The first ten causes accounted for 72.8 per cent.
- 3. Those who due to pre-existing or occupational conditions required a change of occupation: old injuries and deformities, 20.6 per cent; pneumatic arm, 10.0 per cent; fumes, 8.6 per cent; chest conditions other than tuberculosis, 8.6 per cent; general debility, fatigue, etc., 6.0 per cent; arthritis and rheumatism, 5.3 per cent; eyes and vision, 4.6 per cent; upper respiratory infections, 3.7 per cent; ears and hearing, 3.5 per cent; other alimentary conditions, 3.3 per cent. The first ten causes accounted for 72.2 per cent.

Here we found an interesting development, a condition termed "pneumatic arm", which may occur from the use of pneumatic tools. This is a compensable condition. If recognized early and the occupation changed to work without much strain, a rapid improvement may be expected. If allowed to progress,

inflammation or even organic changes supervene. In one year, of the sixty-four claims for lost time from compensable illness, thirty-five were for "pneumatic arm".

From a study of the general records the following conclusions are drawn:

1. Conditions found at the physical examination were probably quite similar to those of the same age group in the general public.

2. Women, some of whom have had their third physical routine examination, showed a general history of good health with few occupational illnesses.

3. Occupational illness is not a major

problem in our yards.

- 4. Analyses of paints show that very little lead paint is used in the ship-yards. The hazard of lead poisoning is not an important factor.
- 5. Welding and burning fumes, as far as can be determined, have not been responsible for any change in the type or degree of illness in the Vancouver shipyards. Repeated examinations and consultations show that welders and burners enjoy at least as good health as do other tradesmen. Other findings show that welding and burning fumes have no specific part in the cause or progress of tuberculosis. No case of acute pulmonary edema or fume fever has been reported. Chemical analyses do not show dangerous concentrations of fumes.

Prevention is a 'long-term' program. In some respects the degree of efficiency reached can never be determined. Past and present figures can be compared, if there are past figures. In a war industry they are rare. Sickness absence rates, previous to two years ago, are not available.

Figures for one aspect of prevention can always be obtained. Industries are responsible for the cost of medical treatment, lost time compensation and accidental deaths as a result of occupational injury and illness. Fatalities in the steel ship-building industry were eighteen accidental deaths in each of the past two years.

The trend of industrial accidents in the other major B. C. industries has been upward. In 1944, compensation rates for heavy industries varied from 11½ to 3 per cent of the payroll. Frequency and severity rates of ship-yard accidents were substantially down compared to 1943. The corresponding reduction in compensation rates resulted in a saving to B. C. yards of over half a million dollars. This was attributed largely to the work of the safety, medical and first aid departments.

This type of health service produces tangible and intangible benefits. Some of the tangible results are that workers are supplied with the knowledge of correctable defects, the early signs of degenerative disease and the necessity for treatment. Appointments are made with the family doctor and the clinic. By recheck examination their response to treatment is observed. Where a health hazard is found, suitable control measures are instituted.

Among the intangible results, which cannot be readily evaluated, is the opportunity to assist with the adult public health education of the community by individual health teaching and the interpretation of the functions of the existing agencies. General health supervision has maintained and improved the health and earning capacity of the workers. This has resulted in improved morale, healthier and happier workers, reduced accident rates, better labor relations, improved work, the saving of hundreds of thousands of dollars and the production of more ships.

Tuberculosis Survey of a Rural Municipality

In June, 1944, the first x-ray survey of a rural municipality in Manitoba was conducted by the Manitoba Sanatorium staff using a 35 mm. machine. The district covered was about twelve by thirty miles and the population, consisting of French, Belgian and Anglo-Saxons, numbered between three thousand and thirty-five hundred individuals.

The request for the survey was made to the superintendent of the Manitoba Sanatorium by the Council of the Municipality. The doctor in charge of the survey work met with the Council and outlined the organization which would be needed and suggested the type of publicity which would be most effective.

A letter explaining the purpose of the survey was drafted and also a poster announcing the date and time when each district should report to the survey centre. The Municipality was divided into districts with one councillor responsible

for each. He saw that every family received a copy of the explanatory letter and that posters were put up in conspicuous places and he also arranged transportation for families unable to provide their own. The interest of the clergy was enlisted and an announcement of the survey made at services on two Sundays previous to the date set.

The more such a project can be a truly community effort the more successful it is likely to be, so the public health nurse left most of the organization and publicity to the committee. She was busy meanwhile visiting the convent schools and any family which any councillor felt needed further persuasion.

The Committee, headed by the secretary-treasurer for the Municipality, also arranged for volunteer helpers for each session the survey was operating and included three registrars, two helpers for the women's dressing rooms and one for the men. The survey ran six days from 2.00 to 5.00 p.m. and 7.00 to 9.00 p.m.

Survey quarters were the basement of one of the churches and adequate privacy for dressing rooms and x-ray was provided by the liberal use of clotheslines and sheets.

A total of 2,807 availed themselves of this opportunity. It is rather interesting to compare the first travelling clinic held in this district in 1928, with the present survey. In 1928, of 176 people having x-ray, 13 had tuberculosis, 7 being diagnosed for the first time. In 1944 out of 2,807, 12 had tuberculosis, 4 being diagnosed for the first time.

ELSIE J. WILSON
Nurse Consultant,
Tuberculosis Nursing, Manitoba
Bureau of Public Health Nursing.

Milk is a Valuable Food

Milk is not a perfect food but is the best individual one known. It contains materials which produce energy, foster growth, take care of the repair of worn out muscle tissue, and which, together with vitamin D, can look after the formation and upkeep of bones and teeth. It is a fundamental food for human beings of all ages. However, milk does not contain all the food requirements in correct proportion. It is about 84 to 85 per cent water. It contains an emulsified fat, commonly known as butter which is chiefly digested in the stomach. All other food fats take much longer to break down and are digested in the intestines. The protein of milk has all the factors which sustain life as it contains important minerals and vitamins. However, it is deficient in iron, iodine, vitamin B₁ or thiamin and vitamins C and D.

Milk is a "Jekyll and Hyde". Considered a fine all-round food, at the same time it is a culture medium for fermentative, putrefactive and virulent disease germs. Dr. John R. Fraser, of McGill University, has stated that "unsafe milk has been responsible in the past for more deaths and illness than all other foods grouped together". And even clean milk can be unsafe, despite all possible precautions at the source of supply. Therefore, milk must be put through some process that will kill disease germs before it is bottled in order to make it safe. That process is pasteurization.

-Health League of Canada.

Obituary

Nurses throughout Saskatchewan and elsewhere in Canada learned with deepest regret of the passing of the late Dr. W. C. Murray, President Emeritus of the University of Saskatchewan. Those who have been privileged to know Dr. Murray and to have had personal contacts with him realize that in his passing the nursing profession has lost a real friend.

The Nurses Registration Act passed in Saskatchewan in 1917, and many other progressive developments affecting the nursing profession, were due in a large measure to Dr. Murray's support and unfailing interest.

At the time of his death Dr. Murray was also chairman of the Board of Governors of the Saskatoon City Hopsital. A fitting tribute to his untiring efforts in this capacity was paid by graduate and student nurses from the Saskatoon City Hospital who attended the funeral and formed a guard of honour while bidding silent farewell to one whom they had always held in high regard.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A

The Ideal Characteristics of a Nurse

L. EVELYN HORTON

In a nursing school the importance of keeping the ideal characteristics of a nurse paramount is of vital importance, not only for the director and instructors, but the entire nursing staff personnel including supervisors, head nurses, and general staff duty nurses.

Possibly in no other profession is example and precept so important as in the nursing profession. Every staff duty nurse whether she wants it or not is going to be a teacher. Next to experience the best of all teachers for nurses as well as other pupils is a good example. No nursing staff can hope to attain the best standards for the students in the school unless each and every one is willing to sacrifice.

The characteristics of a good nurse may be divided into three groups:

1. Certain traits are basic to good nursing and rest upon already accomplished habits and attitudes.

2. Other traits are also basic to good nursing and can be acquired in training.

3. Still other characteristics are special nursing skills, which can be learned only through constant practice and study in training.

The student nurse is made aware of these characteristics on application, and in introductory lectures after entrance. As many of these characteristics are acquired through training, it is essential that they should be kept constantly before her as a goal. This is the responsibility of all members of the nursing school faculty and especially the supervisors and head nurses because of their constant contact with student nurses during the immediate situation where these necessary characteristics or the absence of them will be displayed.

An outline of these characteristics with which we should all be familiar will be discussed under the three groups noted above:

1. The basic prerequisite traits upon which the acceptance of a student into a school of nursing is based. These are fundamental traits, which can be changed only with extreme difficulty, if at all.

(a) Is healthy—physically and mentally (full discussion, pages 44-46, Mental Hygiene for Nurses, Vincent). A complete physical examination before entrance is essential. Health is defined as that quality of life that enables us to live most and serve best. The nurse who herself is exhausted cannot give good service.

(b) Good intelligence — the value of intelligence tests for applicants is debatable. They are being carried out by some schools of nursing before acceptance of students. As junior matriculation has been set as a standard, and as a definite degree of intelligence is considered necessary for a student to achieve junior matriculation (I.Q. 107-120), many educationalists believe this to be

sufficient for entrance. All schools of nursing would do well to raise their standards of entrance to senior matriculation. A record of the students' academic experience and the marks made gives a valuable clue as to what can be expected of her in the school of nursing. Generally speaking, from experience I have found a student can be expected to continue at about the same level. Where she possesses other qualities essential for nursing her success is more assured than if she lacks these qualities.

(c) Personality is of very great importance. What the nurse is as a person, is as important as the skills she will acquire in nursing procedures. We do not always show consistency in our personality traits - they change with emotional variations. The nurse like the gifted actress must possess a versatile and flexible personality. She must be a real person. As Emerson Fosdick has put it in his recent book, "On Being a Real Person," "Personality is not so much like a structure as like a river . . . it continuously flows, and to be a real person is to be engaged in a perpetual process of becoming". He also says, "A real person is integrated, and achieves a high degree of unity within himself. Some individuals are like a brush heap, a helterskelter, miscellaneous pile of twigs and branches; others like a tree include the same kind of material but are organized into a vital growing entity. As growth continues, selves appear. There is the self one is at home, the self in business, in church, the golf links, etc. Often these multiple selves are in bitter conflict -Dr. Jekyll and Mr. Hyde. Personal wholeness and unity is necessary for happiness and health".

"Happiness", said Dr. William Sheldon, "is essentially a state of going somewhere wholeheartedly, one directionally, without regret or reservations". To be all at odds with oneself is to be unhappy. Many of the great people in the world have had a desperate time finding themselves. Florence Nightin-

gale wrote in her diary, "In my thirtyfirst year I see nothing desirable but death".

The nurse's personality plays an important role in the sick room. In addition to nursing care the nurse has many other relationships to the patient. Her professional competence is usually taken for granted and it is often in these other relationships that she can find unique opportunities to promote the welfare of the patient and guide him forward toward recovery. The nurse must be able to adjust to the sickness situation, and the complexity of moods and attitudes that characterize most sick persons. Courageous optimism must be one of her permanent personality traits. She must have an even temperament, not moody or easily depressed. She must be able to maintain courage in others, renew hope and strength, be dynamically sympathetic. The nurse should cultivate individuality, which will make her more interesting to the patient. In adjusting herself to the sickness situation the nurse's general cultural and educational background is of assistance. Visitors come and go but the nurse is constantly with the patient. The nurse who has a varied general education, who keeps well informed on the news of the day, including politics, books, plays, sports, and who is able to draw discriminately upon her own experiences and observation is not likely to lack appropriate topics of interesting conversation for the convalescent patient.

There is some skepticism among educationalists as to the value of personality tests. Actual observation in different situations, when the student is not aware she is being studied, is the best means of judging personality. The preliminary period in the nurse's training is well suited to this purpose. The value of personal recommendations depends on the motivation of the person writing them.

2. Other traits are also basic to good nursing, and can be acquired in training. These characteristics may be briefly summarized as follows: (a) patience; (b) orderly methods of working; (c) control of one's temper; (d) an increasingly sympathetic understanding; (e) tolerance; (f) a cosmopolitan viewpoint and set of appreciations; (g) selfconfidence; (h) ability to get along satisfactorily with other people.

If a student nurse already possesses these qualities, she is spared much effort in learning and will probably be able to reach a superior position in the nursing profession. If she needs to acquire many of them she will have to concentrate harder and work more seriously. Success sometimes is greater when a nurse has to struggle to develop herself. Struggle with one's self, if ultimately successful, gives one the finest possible basis for understanding and helping other people. Constructive criticism and praise well-earned will help students to gain these traits.

3. Still other characteristics are special skills which can be learned only through constant practice and study in training as, for example, acquiring skill and efficiency in: (a) manipulation of sterile technique; (b) handling patients; (c) recognizing symptoms; (d) making accurate and helpful observations; (e) hospital and sickroom routine.

These will come through serious study, prolonged practice, constant alertness to the necessity for learning everything possible about the profession. Since repeated performance is needed to gain efficiency in any art, the necessity of students being given the opportunity to repeat procedures which they are prepared to do is important.

The following are some general considerations regarding the educational program for student nurses. All members of the nursing school faculty should be prepared to assist both in building and carrying out the plan of education. Supervisors and head nurses should have a general understanding of the entire educational program both clinical and classroom, and see the relationship of

their part to the whole. They have better opportunities than any other members of the staff to help the students to see the importance of relating theory and practice and therefore should be familiar with the fundamental principles of teaching and learning. These are outlined in "The Hospital Head Nurse" by Wayland. Of these I want to mention particularly the fifth, namely, "the importance of immediate application of knowledge". As soon as the student has been taught the theory underlying a procedure, and techniques have been demonstrated, opportunities should be provided for her to carry out the procedure in the real situation. If the knowledge previously taught is to function, guidance must be given in making the right application, and in knitting together theory and practice. Without this final step much of what is taught in the classroom will be wasted.

To carry out these steps economically and competently a program must be planned in each clinical division to which students are assigned and definite provision made for carrying out the plan.

In carrying out procedures on the ward, though they may have been well taught in the demonstration room, the student will need some additional instruction the first time she performs this procedure on the ward. It should not be necessary to reteach the lesson but simply to help the student recall what she has already learned, and apply it to the immediate situation. In many instances, depending on the nature of the procedure and the condition of the patient, additional assistance may be necessary the next two or three times treatment is repeated. Young, inexperienced students should not be exposed to nerve-racking ordeals without someone at hand to give them a sense of confidence. Supervision should be, therefore, more concentrated during the period when students are making their first adjustments to a new type of experience.

It is important to remember that in-

dividuals differ in their mental and physical capacities and reactions, and consequently that progress is an individual matter. We must learn not to expect all students to attain the ability of the superior students in any group. Also, we must be aware of the importance of comparing a student with other students in the same group, and not with more experienced students. The head nurse or supervisor should keep before her as a basis a knowledge of what can be reasonably expected of the average junior, intermediate, and senior student. By the consideration of these points and a knowledge of what to expect of an average student at different phases of her training the ultimate aim of nursing education will be more fully realized.

The following is a very general outline of the levels of ability which might be expected:

- 1. The junior student A typed list kept up-to-date of procedures covered with pre-liminary and junior students and posted on the wards proves very helpful to head nurses. By the completion of the junior year, students should have had demonstration and practice in all the general nursing procedures and with sufficient supervision should be able to carry these out in the wards. The junior student should not be assigned to the critically ill or extremely difficult patient, or unusual cases. They should not be given full responsibility for any such work as medications, dressings, diets.
- 2. The intermediate student Early in the intermediate year students should receive operating room experience, which gives them

a keener appreciation of asepsis. They can now be expected to take more responsibility for surgical technique and other duties on the wards. They should perform the general nursing care and treatments more efficiently and with less constant supervision. During this term the student receives her obstetrical training which is in many ways an entirely new experience. However, she enters this department with a good foundation in medical nursing, surgical nursing, and operating room technique. The related lectures in obstetrics and obstetrical nursing if possible should be given concurrently with this experience.

3. The senior student — Much of the senior student's time is spent in affiliations and in special departments such as pediatrics, isolation, public health, out-patients' department, sanatorium, psychiatric. During her time spent on the wards it is reasonable to expect this student to carry some of the executive work and more advanced duties. This again should be done under careful guidance from supervisors and should prove invaluable in the training of the nurse for her future work.

The practical work card which is checked as soon as the student successfully performs a treatment, and which accompanies her from one department to another, should be of assistance to supervisors and head nurses, acquainting them with what the student is prepared to do, and also with the experience required by the student.

"The entire object of true education is to make people not merely do the right things, but enjoy the right things". — Ruskin.

Preview

Very much is being written in current magazines and the press concerning the return of the thousands of young men and women who are in the various services to civilian life. For months, too, the Canadian Broadcasting Corporation has had qualified doctors, psychologists and others speaking regularly on the same topic. We are glad to be able to present as our feature for June Dr. Ewen Cameron's very able presentation of this subject.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses
Association

Setting the Social Climate

MILDRED I. WALKER

In the earlier articles dealing with the problems of supervision an attempt was made to show why and how the change from the authoritarian form of supervision to the more democratic form has come into being in public health nursing organizations. Two cogent factors have emerged from this new emphasis; first, that it is necessary that all members of the staff should be capable of adult behaviour; and, second, that if they do not seem to have the ability to accept their part in democratic thinking and planning, this fault may be due to some previous experience under a less favourable form of supervision. In other words, the public health nurse who is mature emotionally should be competent, not only to plan for and carry out her health program in the community but also to contribute her share to the thinking and development within the organization itself. We have seen that leadership is necessary to achieve these ends - leadership which in its truest sense provides for and encourages active co-operation from the whole staff. Given adequate leadership and well coordinated staff, supervision assumes a truly democratic meaning, and a democratic atmosphere or social climate is created within the agency.

The social climate which is developed within a public health nursing organization is an important factor to be considered. It directly influences perfor-

mance in both the immediate and longterm supervisory planning. A social climate may be defined as the atmosphere or tone which results from the mutual relations of people through living and working in an organized, interdependent body or society. Let us make a study of the forms of social climates which may be set up within a public health nursing group through the interaction of its members and others directly and indirectly associated with the health service. Each individual might apply the information to her own situation and decide which climate would give the most satisfactory results in the light of her evaluation.

Studies which have been made indicate that there are three main climates which may be created: authoritarian. democratic and laissez-faire. It has been stated that "the varieties of democracies, autocracies and laissez-faire atmospheres are, of course, very numerous. Besides there are always individual differences of character and background to consider". When the nurse attempts to evaluate the social climate in which she serves on the basis of these experimental studies, she must consider all the factors of individual differences and background and evaluate them objectively. This will not be done readily because she herself is a contributing factor to the group reaction.

The following outline indicates the

MAY, 1945

methods by which the three varieties of social climates were created experimentally.

goals were set by the individual in charge. Apathy disappeared when the authoritarian leader left the room, indi-

Authoritarian

1. All determination of policy by the leader.

- 2. Techniques and activity steps dictated by the authority, one at a time, so that future steps were always uncertain to a large degree.
- 3. The leader usually dictated the particular work task and work companions of each member.
- 4. The dominator was "object-"personal" in his praise 4. The leader was "object-ive" or "fact-minded" and criticism of the work of each member. but remained aloof from active group participa-tion except when de-monstrating. He was friendly or impersonal rather than openly hos-

Democratic

- 1. All policies a matter of group discussion and decision, encouraged and assisted by the leader.
- perspective 2. Activity gained during first dis-cussion period. General steps to group goal sketched, and where technical advice was needed the leader suggested two or three alternative procedures from which choice could be made.
- 3. The members were free to work with whomever they chose, and the division of tasks was left up to the group.
- in his praise and criticism, and tried to be a regular group member in spirit without doing too much of the work.

Laissez-faire

- 1. Complete freedom for group or individual decision, without any leader participation.
- 2. Various materials supplied by the leader, who made it clear that he would supply information when asked. He took no other part in work discussions.
- 3. Complete non-participation by leader.
- 4. Very infrequent comments on member activities unless questioned, and no attempt to participate or interfere with the course of events.

The resulting behaviour in these artificially-created social climates demonstrated many tendencies which are of interest to the public health nurse. In the authoritarian climate the results of aggressive domination were shown by the participants; to the leader the response was submission and persistent demands for attention; there was hostility, criticism, expressions of competition, and ego-involved language; individuals who had proven to be leaders in the democratic environment became scapegoats in the authoritarian, made excuses and left the group; there was little incentive for initiating new projects; there was little smiling and joking, and there was tension due to frustrations when all

cating that the removal of pressure gave release to the emotions. Strikes and symptoms of rebellious action occurred, the degree of rebellion or submission being dependent upon the pressure of forces from within as compared with the forces exerted from without. The unwillingness of the group to accept pressure was amply demonstrated.

In the democratic situation the interaction was more spontaneous, factminded and friendly. To the leader the response was free and on a basis of equality. There was a moderate amount of aggression. When the students transferred from the authoritarian or hightension atmosphere to the democratic there were outbursts of aggression, confusion and running around until they became adjusted to the situation of less pressure and more freedom for setting individual goals.

The laissez-faire atmosphere, due to lack of direction and indifference on the part of the leader, soon indicated loss of interest and productivity although preference was expressed for this disorder rather than the rigidity of group structure created by authoritarian direction.

In the summary of the experiment, four main factors were found to create aggressive behaviour: (1) tension; (2) restricted space for free movement; (3) style of living; (4) rigidity of group structure. Aggression is the invasion of rights, as defined by the dictionary, and it challenges the supervisor to ask herself, "Is my direction imitating the authoritarian pattern? Is all the work being directed by me? Am I permitting my staff to set goals and attain them? Have I enough confidence in my own direction and the abilities of my staff to permit them an equal share in planning and working out the program? Do I dictate every step of the way? Do I emphasize techniques or principles? Do I permit flexibility in following procedures? Am I objective or fact-minded in my praise or criticism or am I 'personal'? Do I consider personalities or the total situation and the objectives of the program? Am I always constructive? Do I, in making plans for future work, discuss it first with the group, or do I make the plans and 'tell' them what they are to do?" The supervisor must remember that while techniques and principles are both necessary, principles are more fundamental. Techniques are to be applied in relation to the principles involved. Also that the total situation and the objectives of the program must be considered above personalities. In the truly democratic organization the group would consider its needs and plan accordingly.

In an attempt to be democratic the

leader may err and create the laissezfaire climate because she does not wish to "interfere" with the staff in planning. Democratic leadership is not interference. There is a place for advice and guidance when the nurse has not time to find out all the facts in the situation and reach her own conclusions. The supervisor is the expert and as such is a resource for the nurse. Advice must be accepted too when the individual is too subjective, is too close to the case emotionally to make a decision, or is not sufficiently informed on the subject. Advice has its place but it must be reasonable and applicable to the specific instance. It is realized that sometimes the individual nurse may even be permitted to fail, because, providing no injury is done to the project, this failure becomes a valuable teaching experience for her.

When dissatisfaction is found among the staff, the supervisor should take warning of future trouble. Frequent resignations, rebellion, apathy, lack of responsible behaviour all may indicate an authoritarian climate to the wise supervisor. The executive who attributes a procession of resignations over a period of time to ill-health, "personality" problems and all the other excuses put forward, is acting blindly, and is not fact-minded. It may be the personality of the supervisor or it may be one member of the staff. If it is the latter who creates the difficulty, and the supervisor is democratic, fact-minded, the group will soon correct the problem. If the difficulty lies with the supervisor the situation is more difficult unless the supervisor is truly democratic and can evaluate herself objectively.

The first cause of aggression noted is tension. This is affected by the personality of the leader or supervisor. In the field of guidance and in administration, the social climate develops from the top down. The executive officer or the person who directs the service has been referred to as the planner, the integrater

and the "spark-plug" of the organization. This is a big order but those who guide others accept this as a part of their responsibilities. Schell₂ says there are three qualities essential for a good executive. These are: innate interest in and affection for people; strength and power of personality; scientific trend of mind. This strength and power of personality may create tension or it may set up a democratic social climate through direction and example. Tension or pressure will be avoided if the leader or supervisor possesses these three qualifications and a democratic social climate will result.

The other three factors which create aggression—lack of space, rigidity of group structure, culture or style of living-may be found among a staff and the supervisor may not be able to correct them. As soon as there is an awareness of the situation, a remedy should be sought. If the difficulties cannot be overcome the supervisor should accept them, by-pass them, or resign from her position. She should not complain ineffectively. Restricted space causing lack of free-movement may occur when there is inadequate office space for the staff. The office and conference rooms of the public health agency should fulfil the principles of health. They should be spacious, well-ventilated, well-lighted, clean and attractively decorated, and free from hazards. In the hospital pressure may be created through lack of free space because of the large number of people who live in a nurses' residence. Frequently, too, the hospital has been surrounded by other buildings leaving very little free space. One hospital, turning a liability into an asset, has made an abandoned reservoir into a swimming pool, to the delight of all the staff. Without leaving the grounds in off duty hours, the young people can acquire that coveted coat of tan to compete with those who may have more free time to go to the beach. Other hospitals have roof gardens for recreation. These assist in the release of pressure due to restricted space, and limited time. (Did you ever know a nurse who had enough time?)

Rigidity of group structure is frequently a problem which creates real difficulty for the nurse who serves the community, especially when the service is new. For her first six months or year the community watches her very closely, especially if it is semi-urban or rural area. They are suspicious of anything new especially if it emanates from the city. This is true also of the young teacher and in many cases the public health nurse may assist her to understand the mores and customs of that particular community. These group structures may be unknown to the new comer despite the fact they may be rigidly adhered to by the community. Any change creates a problem and probably considerable pressure. In pre-war days when personnel was more plentiful, many communities engaged only "home-grown" personnel. Hospitals closed their staffs to outside graduates. This has been broken down and we hope will be avoided in the future post-war planning for nursing services in Canada.

A style of living or culture may be a contributing factor to aggressiveness, creating pressure on staff. It may be that some nurse belongs to a cultural group which encourages an aggressive pattern of behaviour. It may be that she does not come from a home where all share equal status in the family unit. In her home situation, there may be one member much more dominant than the others which tends toward an authoritarian climate.

Of particular assistance to me has been the careful observation of the behaviour of students when transferred from an authoritarian climate to the democratic. The release of pressure creates confusion and lack of self-discipline until the student becomes accustomed to the atmosphere of lessened pressure. Some of our students show

interesting behaviour reactions when they come from a hospital atmosphere which has been authoritarian to the democratic climate of a university school. Here they are accepted as graduate nurses who are sufficiently responsible to meet the requirements outlined in the university calendar, such as attendance, field trips and assignments. It is interesting that the general reaction is different each year but with some guidance the students make their adjustments and emerge with the form of behaviour acceptable for the public health nurse.

Our aim in supervision in public health nursing is to create the democratic social climate. We have been reminded there is no short-cut to democracy. It is slow, halting and beset with many difficulties. The expert in the situation may be impatient to get things done. She knows, and wishes to go directly to the solution of the problem as she sees it. However in the democratic climate it is not possible to have a oneman show. So the supervisor who is the expert must do all that is possible to assist all members of her staff to participate, share and contribute according to the ability of each individual. Richards, says, "Real teaching cannot be achieved without time, patience and genuine interest in human beings on the part of the faculty group". So it is in supervision in public health nursing. Democracy emphasizes personal worth of the individual; for the group, preeminence of the common good; that authority be derived from the group. The ultimate authority of a public health nursing agency is vested in the people served. They are the reason for the existence of the service. Lindeman4 says "To be responsible does not mean to submit to authority. On the contrary it implies the joint creation of authority". A genuine atmosphere of responsibility is produced when all participants achieve personal dignity. If an individual is unhappy in a job, she can find plenty to criticize. The nurse on the staff must belong and she must feel her work is important to the program. It really takes determined effort on the part of all to create the democratic social climate. The good executive is a good teacher as well as a good leader. The democratic supervisor in her desire to be an intelligent leader will face her problems and accept the responsibilities of her position.

If the supervisor feels the behaviour pattern is not satisfactory, and there seems to be an unusual amount of pressure or tension, she should think of the four points which may play a part: tension due to personality problem of one individual thinking first of herself; restriction of space for free movement; rigidity of group structure; style of living or culture. Most important of all, the leadership should be positive, uplifting and integrating to give the staff the pleasure of knowing achievement.

It will take concerted effort on the part of all of us in public health nursing - administrators, supervisors, and staff-to make effective the democratic way of life. With a change in the meaning of supervision from inspection, superintendence or oversight, to that of guidance, it is necessary to change our way of thinking from the traditional or authoritarian to the democratic. This requires our constant consideration because we have been educated in the general field of education and in the special field of nursing by traditional or authoritarian methods. Public health nurses are truly interested and respond readily to group discussion regarding the creation and maintenance of the democratic social climate. Experience in the field of public health nursing indicates that the nurse who is attracted to this field has an outgoing personality. To function successfully requires a high degree of interaction which can only be maintained by respect for the individual and for group effort on the part of the whole staff where the contribution of each is equally important to the smooth functioning and maintenance of a well-integrated program of community service.

Supervisors and administrators are interested because they need to encourage those who show leadership qualities so that there will be a steady supply of qualified nurses capable of assuming greater responsibilities. Leadership emerges in the democratic process. The supervisor recognizes in the young nurse these qualities and then guides her by the democratic process of thinking and action. If there is a scarcity of qualified leaders in a field there has not been education for leadership. The nurse giving leadership tomorrow must be one who has the capacity for leadership, has qualified scientifically for it, and will assume gracefully the responsibilities which are

a part of the position. She must think and act democratically and require this of her staff. This will be true leadership by which the democratic social climate may be maintained.

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Nursing Sisters' Association of Canada

At the recent annual meeting of the Edmonton Unit there was a record attendance. The president, Mrs. E. Porritt, was in the chair. Reports showed that the thirty-three members had raised about \$500 which was contributed to Russian, Greek, Chinese and merchant marine funds, as well as to the British Nurses Relief Fund. After the meeting the hostess, Mrs. Harold Orr (N/S Margaret West), entertained at a turkey supper, a splendid climax to another year of successful endeavour. The majority of the members are engaged in various war activities and in April the Unit celebrated its 25th birthday.

The Montreal Unit held their annual Armistice dinner with fifty-six members present. The guest speaker was Mr. K. C. Woolley, secretary of the Canadian Legion. The Unit sent a letter to the Rt. Hon. Mackenzie King wishing to go on record as supporting in full the principle of total war and to protest the action of the government in ignoring the plebiscite taken by them regarding conscription. The Unit continues to assist the British Mine Sweepers Auxiliary in addition to other individual voluntary work.

In conjunction with the Red Cross, members of the *Toronto Unit* during the war have had three afternoon groups and one evening group working in their rooms at 2 Bloor St. E. Last year, under the leadership of Mrs. Jack Bell, these groups made over fifty-three thousand surgical dressings. Every Monday several members pack prisoner-of-war boxes. A bridge was held in April, the proceeds to go to war work.

Personal Notes: N/S Ethel Greenwood, for four years at Camp Borden, recently retired

"STAMP OUT VD" CAMPAIGN

The Health League of Canada and the Canadian Pharmaceutical Association have joined forces to stage a special "Stamp Out VD" campaign from May 21-26. In this special campaign Canada's 3,865 operating druggists are being asked to co-operate through window, counter and showcase displays.

Special efforts will be made to interest youth in the fight against VD. About 75 per cent of all VD is acquired by persons under thirty years of age.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

A Day in an Indian Hospital

OLIVE THOMAS

There are many nurses who have not the slightest conception of life in an Indian hospital, and yet there are such hospitals in every province of the Dominion. An Indian hospital treats the same variety of patients as any other. This one of which I write also has a department for tuberculosis.

In the early morning the usual routine is carried out by the night nurse, wakening and preparing all for breakfast. There is an added joy in the little girls' tuberculosis ward, watching these little bronzed people, with big black eyes, shining white teeth, smiling faces, displaying great eagerness to be awake and ready for the activity which comes with the daylight. While clasping an orange tightly in one hand, they dive into a bowl of porridge-for this must be eaten before they are permitted to enjoy toast, jam and milk. Next comes the bath, with clean linen and pyjamas. How they love pretty, clean pyjamas! Each is given her own with name attached. Thinking of conditions in some of their homes, one wonders at the criticism and look of disgust on a wee face if her sheet or spread, when opened up, displays a cocoa or medicinal stain, for which probably she was the guilty party on a previous occasion.

In addition to the routine duties in the hospital administration there is the activity in the out-patient department, which demands the full attention of one nurse. Frequently there is a steady stream of natives in and out of the doctor's office. Several dozen teeth may be extracted during the day. Prenatal examinations are routine and gradually are being accepted by the younger generation. Physical examinations are given; x-rays taken; fractures set; casts applied; many consultations are held and advice given to one and all coming into the office.

Suddenly a loud and persistent ringing of the bell calls the attention of every one. Looking out of the window one sees a sleigh drawn up to the door containing, what appears to be, nothing but a huge pile of quilts and blankets. On further investigation and unfolding of many layers, a child is revealed, pale, limp and emaciated. One glimpse of the trained eye and, immediately malnutrition registers on the mind. The mother reports that the child is getting thin, and since the previous day has been unable to retain feedings; the cry is weak and pitiful. The baby is admitted to the hospital amid the weeping and wailing of the parents, as the child has become too frail to give much encouragement for recovery. For the interest of the readers, I would add that the baby was discharged four months later, having developed into a sturdy little chap with no evidence of malnutrition remaining.

Another ring at the bell and, minus all ceremony, in rushes a young Indian

MAY, 1945

with his wife following slowly behind. "My wife, she sick, Doctor home?" It takes but a few moments for the nurse to realize there is no time to lose. The young woman is admitted, put to bed, bathed and wheeled into the case-room. Not long after, a hearty protesting yell announces the arrival of a chubby infant; particularly fascinating is the heavy mop of black curly hair. In a short time the mother is comfortably settled and enjoying tea and toast. The young daughter is oiled, bathed, dressed and settles herself to enjoy her meal. Generally speaking, Indian babies are ready for a full course meal from six to twelve hours after birth.

The staff decides it is time for a moment of relaxation and retires to the living room for tea; unfortunately this recess is of short duration. A nurse is again summoned to the door as an excited twelve-year-old boy, holding one hand in the other, says, "I cut off my

finger". He is taken into the examining room and, right enough, one finger is practically severed and others badly mangled. Once more the doctor and nurses get busy. The operating room is made ready, doctor scrubs, and the nurse administers the anesthetic. The finger is removed, wounds cleansed and necessary repair done on the hand and remaining fingers. The child is carried into the ward and into the only empty bed in this busy little hospital.

Thus ends the emergency work for the day. With the busy out-patients department, operating room and case room all brought into activity, not a dull mo-

ment is known.

Any nurse who thinks that life in an Indian hospital is an uninteresting and monotonous existence might take a few moments off some day, study conditions and accept a few facts from others who have learned from personal experience.

Concerning Shock

War, with all its horror, always adds to medical science and nurses will find the second edition of the Medical Research Council's War Memorandum No. 1 on The Treatmen, of Wound Shock a very helpful contribution to their knowledge as are also the many numbers of the Bulletin of War Medicine. These bulletins are published by His Majesty's Stationery Office, House, Kingsway, W.C.2, or 13a Castle Street, Edinburgh, 2, price 6d and 1/3 per copy, respectively. The new edition of the Medical Research Council's Memorandum on the Treatment of Wound Shock differs extensively from the first edition, not because of the discovery of "any 'dangerous' statements" in the first edition but because fresh evidence, new points needing emphasis, and modifications of treatment have necessitated a complete rewriting. The new edition puts the present position of our knowledge of this difficult subject very clearly and is most valuable.

In this edition the word "shock" is put in quotes throughout, because of the great complexity of the "shock" problem — the many factors which help to cause it, and the various different manifestations associated with it. Among the causes, the memorandum stresses the importance of acute reduction of the blood volume or oligemia, resulting from hemorrhage or plasma loss, either externally, as in extensive burns, or internally into damaged tissues, as in crush injuries.

It also draws attention to the vasovagal collapse which not infrequently complicates the picture in hemorrhage and acutely painful injuries, even in

trivial injuries in susceptible persons. Here a sudden fall in blood pressure occurs with a slowing of the pulse because of vasodilation, affecting especially the arteries in the muscles. It usually occurs early after injury, with a feeling of faintness or actual loss of consciousness, but it can occur late, and may follow manipulation, operation, or further hemorrhage when the first bleeding has been arrested.

Again the memorandum stresses the importance of early recognition when the appearance of the patient and the blood pressure may be deceptive. With regard to hemorrhage, it reminds us that a loss of up to two pints may be tolerated with little or no obvious effect or fall in blood pressure, because of the compensatory effect of vasoconstriction in the skin and internal organs. Indeed, it draws attention to the fact that in the early stages after injury there may even be a 'post-traumatic hypertension', (150-170 mm. Hg.), the cause of which is uncertain. Under these circumstances, it gives the good advice that every case of serious injury, with hemorrhage or without, should be treated for "shock" without waiting for clinical signs to appear.

In the section on treatment, there are many interesting points. First comes the statement that the longer the delay before treatment the greater the danger, so that resuscitation measures should, if possible, be followed by immediate operation or should be carried out in the theatre itself. The value of a special resuscitation ward where the patient can obtain the rest and quiet 'so impossible in a busy general surgical ward', and where measures to restore the circulation — a blood transfusion can be quietly carried out - is stressed. An interesting point here is the statement that the use of nine-inch blocks at the foot of the bed will often raise the blood pressure by 5 to 15 mm. of mercury.

As anyone who has followed air-raid casualty work closely would expect, the

danger of tourniquets receives further emphasis. The memorandum suggests that, where they have been applied before admission, unless the limb has been damaged beyond hope, the tourniquet should be removed and, if hemorrhage recurs, local pressure should be applied on the bleeding point by means of strong bandages and several layers of wool bound tightly over the dressing.

The paragraph on warmth stresses the general change in outlook here. The suggestions are removal of wet and dirty clothes, warm pyjamas, a bed warmed with hot water bottles, and hot drinks. The more elaborate apparatus - the electric blanket, radiant heat bath or "shock" cage - are not mentioned except to condemn them in the statement, "More elaborate heating arrangements are unnecessary, and it is always undesirable to overheat the patient". The danger lies in vasodilation of the blood vessels in the skin, which can hold from a third to one half of the whole of the normal blood supply when the skin is fully flushed with blood. This, of course may increase dangerously the oligemia from which the patient is already suffering because of the sweating that it causes.

The Bulletin of War Medicine for November also touches on this point of warmth in "shock" in an abstract of an article by D. S. Dick from the Lancet of August 5. He had wide experience of resuscitation of battle casualties. The abstract states, "Wards were heated by paraffin 'Valor' stoves to about 80 degrees F., and hot water bottles were applied; the author concludes that the physical and mental comfort of gradual warmth probably outweighs the theoretical advantages of applying heat to shocked patients". As the nurse is the one who is generally responsible for the application of warmth it is important for her to understand the position fully, and the sentence in the memorandum 'enough cover and warmth for comfort are now thought to be the optimum'

might well become her motto provided she remembers that 'cover' includes both what is under and what is over the patient.

Needless to say transfusion is discussed together with the risk of pulmonary edema, and interesting in this section is the fact that in a series of war casualties an average of three pints per case was required, and some severe cases needed an amount approaching the whole blood volume, that is, about ten pints. In fact, did not Glasgow record a case in which the total ultimately reached twenty pints? With regard to rate, 100 cc. per minute can be given in severe cases and if the veins are in spasm a hot water bottle laid over the arm will often relax them. If air pressure is used to force blood in from the bottle, nurses should keep in mind the warning that the bottle must be disconnected before it empties or a fatal air embolism will follow.

The administration of oxygen in high concentration which was advocated in the first edition has not, in practice or in experiment, proved satisfactory and the memorandum suggests that its use be confined to cases of chest injury or pulmonary edema, carbon monoxide poisoning and chemical warfare.

One other point of particular interest concerns crush injuries. Civil defence personnel have had instructions to give sodium bicarbonate by mouth and fluids, such as tea, coffee or water, if possible, before releasing from compression patients who have been buried for more than an hour. Such cases are labelled and should have two ounces of sodium bicarbonate hourly by mouth, till the urine turns red litmus blue, up to twenty-four hours. This is thought to prevent precipitation of myohemoglobin as acid crystals in the kidney tubules, and therefore to lessen the risk of death from renal failure, though the cause and prevention of this condition are still matters for further research.

-Nursing Times

What Do YOU Think?

What are your aspirations for nursing in Canada in the next few years? We have heard rumblings of discontent — but not enough constructive suggestions are being made. The Journal is exceedingly interested to know what the nurses of Canada think about the future of our profession. In order to find out, the Editorial Board has authorized the awarding of prizes for the best articles portraying the influences which will shape this future. What individual nurses think and do, what the profession does collectively, how the public, whom we serve, will shape plans, are all aspects which may be developed.

The competition is open to any Canadian nurse, graduate or student. The articles should be not less than five hundred nor more than a thousand words in length, written or preferably typed (triple-space) on one side of the paper only. Representative nurses from various parts of Canada will be named as judges. All entries shall be submitted to the offices of *The Canadian Nurse Journal*, 522 Medical Arts Bldg. Montreal, 25, and marked "Competition". The closing date for the entries will be September 30, 1945. The winning articles will be published in the Journal.

Prizes shall be awarded as follows: for the best article, \$25; second and third choice, \$15 and \$10 respectively. Other articles of merit will be given honourable mention. It is understood that all articles must be original, have not been submitted elsewhere for publication, and become the property of The Canadian Nurse.

-M. E. K.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

At a recent conference called by National Selective Service with representatives of the Canadian Nurses Association, a careful analysis was made of the supply and demand of nurses for Canadian hospitals and public health services.

During the year the nursing personnel needs of the Armed Forces made fairly heavy demands upon Canadian nurses. It is not expected that the requirement for military nurses will be quite so great during the coming year, but the erection of new hospitals and additions to other hospitals will strain our reserve nursing personnel to the utmost.

At this time last year, when plans were made for recruitment of further nurses, it was believed that there remained a supply of married nurses who could give full or part-time service to their community hospitals, or could relieve the strain upon the private duty group. In answer to appeals, many married women re-entered the profession. This reserve is fairly well exhausted. It was, therefore, decided to again draw to the attention of hospitals the necessity for making full use of their professional personnel for highly skilled nursing service. The following suggestions were endorsed by the Liaison Committee:

That nurses' aides of suitable qualifications and preparation be used as much as possible to relieve the professional staff of all non-nursing duties.

That, where possible, every consideration be given to establishing group nursing for patients requiring the service of private duty nurses.

When a hospital is in a critical situation, insofar as nursing personnel is concerned, that the co-operation of the medical staff be sought in bringing about a reduction of the demand upon private duty nurses.

For those hospitals not already doing so, it is suggested that consideration be given to extending vacations for all graduate staff over a longer period of time, exclusive of Christmas vacation, and that, where possible, consideration be also given to the policy adopted by many business firms, namely, the granting of one week's summer vacation as a bonus for taking regular vacations during other periods of the year.

Many nurses who have not had experience in mental nursing or in tuberculosis sanatoria are hesitant about accepting positions in these institutions; the fear of contracting tuberculosis has also been a deterrent in the latter instance. It is realized that, although this may only be one factor, it is of sufficient importance to give concern and, for those hospitals not already doing so, it was suggested that an introductory program for newly-appointed staff be established, and that a planned program of staff conferences conducted by medical and experienced nursing staff be arranged. It is realized that this requires time and planning and, where possible, the co-operation of the provincial nurses association should be sought, and the services of the travelling instructor, to assist with organizing and conducting such programs, should be obtained.

As a means of maintaining interest

and encouraging nurses to remain for a longer period of experience, consideration should be given to the policy of issuing a statement of experience received at the end of six months' continuous service.

Nurses frequently object to accepting positions in special hospitals because of the isolation. It is therefore suggested that in these instances consideration be given to accumulative leave, which will allow for a brief period away from the institution.

An improvement in the organization of recreational facilities is also suggested

as a means of providing personnel with much needed diversion.

British Nurses Relief Fund

We gratefully acknowledge the following donations received from the Saskatchewan Registered Nurses Association: Maple Creek Graduate Nurses Association, \$25; A. A., Yorkton Queen Victoria Hospital, \$19.85; Yorkton Nurses Voluntary War Services Association, \$30. Total, \$74.85.

Ontario Public Health Nursing Service

Frances Cooper (University of Toronto School of Nursing diploma course) has accepted an appointment with the Peel County School Health Unit.

Jane Fedchyna (Hôtel-Dieu Hospital, Windsor, and University of Western Ontario public health course) has accepted a position with the Windsor Board of Health.

Eileen Morris (St. Michael's Hospital, Toronto, and University of Toronto public health course) has accepted a position with the Oshawa Board of Health.

Alice Klugman (Toronto Western Hospital and University of Western Ontario public health course) has accepted an appointment with the Chatham Board of Health.

Elizabeth Petrie (University of Toronto School of Nursing diploma course) has resigned her position with the Chatham Board of Health to accept an appointment with UNRRA.

Mrs. Blanche Gordon (Toronto Western Hospital and University of Toronto public health course) has resigned her position with the Board of Health of Pickering Township.

Eleanor Wheler, B.A. (Toronto General Hospital and University of Toronto public health course) has resigned her position with the East York Board of Health to accept an appointment with the Department of Health of Prince Edward Island.

Mrs. Mary Donaldson (Proskerniack) (St. Joseph's Hospital, Port Arthur, and University of Toronto public health course) has accepted an appointment as epidemiologist with the Division of Venereal Disease, Ontario Department of Health.

Institute in Chicago

The Department of Nursing Education of the University of Chicago is offering an Institute for Supervisors in Public Health Nursing from June 4 to 9, inclusive. This institute is planned for the nurse who must meet supervisory responsibilities for which she has not had adequate preparation. There will be no registration fee; instructional costs will be met from Federal funds. Maintenance at the rate of \$4.00 a day will be provided for those who do not live in the immediate vicinity. For further information write to Nursing Education, University of Chicago, 5733 University Ave., Chicago 37.

Nursing Education

Contributed by

COMMITTEE ON NURSING EDUCATION OF THE CANADIAN NURSES ASS'N.

Post-Graduate and Added-Experience Courses

This is the first of a series of three brief articles dealing with post-graduate work available to nurses in Canada. The term "post-graduate course" is used to designate a course of a definite length in which carefully organized and systematic teaching is given. In contra-distinction to this, the term "added-experience course" has come to be used to describe the arrangement by which a graduate nurse is allowed to learn the work of a given clinical field or service by working in that field, usually with very slight accompanying teaching, and frequently with none. Thus nurses from small schools often go into the operating rooms of a large hospital to increase their knowledge of this field of work. The first type is usually found in a university school of nursing. While certain hospital schools do offer well organized courses combining theory and practice, these are decidedly exceptional. Many hospital schools when applied to for postgraduate courses refuse to call them this, because they do not give teaching, and prefer to say that they offer only "added experience." Particularly under present conditions, it is very doubtful whether hospital schools can do more than give added experience. Some who formerly offered post-graduate courses have discontinued them.

THE ADDED-EXPERIENCE COURSE:

The purpose of these courses is es-

sentially to supplement the basic clinical training. Depending on that training and the position in view, such courses may occupy anything from a few weeks to long periods spent in one field. Actually the work does not differ from that of the general duty nurse on salary who had been taken on the staff without special preparation or experience in the particular field. It does not constitute a full preparation for this field of work even though the nurse is definitely of the opinion that she wishes to do only general duty by which she means that she does not wish to administer or teach in the department. It is inadequate because a satisfactory general duty nurse is inevitably called on for some administration at times, and because at all times she teaches in the sense that she should provide a demonstration of fine nursing care for new and junior nurses.

Post-Graduate Courses in Universities:

The university nursing schools of Canada offer mainly four types of post-graduate preparation: public health, hospital administration, teaching in schools of nursing, and clinical supervision. Any of these may be taken on either an elementary or an advanced level. In all cases they include both didactic instruction and practice in the appropriate field. In general they occupy one year, and lead to a certificate from the university. Two year arrangements are offered, but so far there have been no candidates for these (except from other countries).

MAY, 1945

Courses in Public Health Nursing:

As few nurses have had public health training during their undergraduate courses, these courses are basic or preliminary training in public health nursing. Preparation is required before work is undertaken in this field. Such a course is now a required qualification for employment in nearly all positions in public health nursing.

In some universities, advanced courses are open to nurses who have had basic preparation for public health nursing, and who also have had experience in the field. The purpose of these is to give opportunity for further study to prepare for work in special fields, or for supervision and administration in public health nursing. Refresher courses are also offered at intervals for those in practice.

Courses in Hospital Administration:

In Canada there are a large number of hospitals with nurse administrators. Nurses have a valuable hospital background, but the board of a hospital looks also for a person who can give business leadership, and can secure and maintain good community relationships and support. Recently there has been a growing trend toward formal preparation for work in this field. Such courses are open to nurses who have already had some experience in junior executive positions in hospitals. In addition to the major subject of Hospital Organization and Administration, courses are given in such subjects as economics, bookkeeping and accounting, legal aspects of hospital administration, psychology and public health.

Courses for Teachers in Schools of Nursing:

These offer preparation for both classroom and clinical teaching. As nursing instructors are probably the people who have the greatest influence in the development of nursing, it is essential that nurses entering these courses should have high qualification personally, academically, and professionally. It is preferable that they should have had experience as general duty nurses, head nurses, or in the public health field. Preparation for these positions usually includes such subjects as psychology, sociology, education, teaching, and science.

Special courses are also offered for advanced or specialized work in nursing schools or hospitals, such as that of the director of a nursing school or the director of the nursing service of a hospital. For those already in the field, refresher and extension courses are offered from time to time.

Courses for Head Nurses and Clinical Supervisors:

These represent the newest type of preparation offered by university schools of nursing. They are, in general, offered for young graduate nurses wishing to work in the hospital field; though even here it is desirable, but not essential, that the applicant shall have had at least brief experience in general duty or as an assistant head nurse.

As many nurses are not familiar with these new courses, the second article of this series will deal entirely with clinical supervision courses.

The third article will list post-graduate and added-experience courses available in Canada.

M.L.IC. Nursing Service

Alice Albert (St. Vincent de Paul Hospital and University of Montreal public health course) has returned to her duties as supervisor on the Frontenac nursing staff, Montreal. Miss Albert was loaned for a

period of one year to the Registered Nurses Association of the Province of Quebec.

Jeanne d'Arc Hamel (St. Sacrement Hospital, Quebec) was recently transferred from Montreal to the Quebec City nursing staff.

Postwar Planning Activities

Contributed by

POSTWAR PLANNING COMMITTEE OF THE CANADIAN NURSES ASSOCIATION

The Great Need for Clinical Supervisors

Six years of war have created many problems in all fields of nursing. What we have done to meet these problems, and what we are doing now to stabilize nursing in wartime, will inevitably have a bearing upon the future character of nursing. This fact must be kept in mind in citing our postwar goals, and in planning for a greater scope and a better quality of nursing in the future.

The Survey of nursing completed in 1943, under the auspices of the Canadian Medical Procurement and Assignment Board, and the national registration, helped us to get our feet on the ground and to know where we stood in regard to many situations relating to nurses and nursing, and has laid the basis for the setting of objectives for postwar planning in Canada.

The shortage of bedside nurses, particularly in tuberculosis and psychiatric hospitals, was stated in the survey as a very serious situation. This situation apparently is becoming more serious as the war continues, and a plea was made in the last issue of the *Journal* that nurses come to the rescue. Unless there is some assurance that nurses will volunteer for service in these special hospitals, we are going to be ill prepared to meet the increased demand for bedside nurses which expanding hospitalization facilities in these services will create.

The time has come when nurses must assume greater responsibility to the pub-

lic for nursing service. We must rise to the occasion now, and make ourselves known and felt by word and deed. The future of nursing in Canada is dependant upon the co-operative efforts of civilian nurses and those demobilized in meeting the nursing challenge of a postwar world.

Another shortage revealed in the survey, as reported by hospitals across Canada, was nurses with special preparation for teaching and supervisory positions. While every effort has been made, through the aid of scholarships, loans and government bursaries to prepare young nurses to fill these important posts, the supply is still not sufficient to meet wartime conditions, nor to deal with the tasks that lie ahead. While many schools of nursing at the present time are having difficulty in securing classroom instructors, the shortage of clinical supervisors seems even more serious, because their absence affects unfavourably, not only the educational program for students in the clinical services, but the care of patients as well.

Nurses in the Armed Forces have been sent, through the Department of National Defence, the official information (P.C. 331) regarding financial assistance for educational purposes upon demobilization. Their overseas experience should be a decided asset in undertaking further study and nursing work. A pamphlet has been prepared by your Committee on Postwar Planning, to be sent to all nurses in the Forces, containing information regarding courses in universities and hospitals, which should

meet the need of demobilized nurses. Before this statement appears in the Journal the pamphlet will be on its way. Returns from the questionnaire indicate that many nurses now overseas intend to undertake some type of post-graduate study upon their return, and it is hoped that the field of Clinical Supervision may be an attraction. Certainly, if supervisors fulfil the function of modern super-

vision, as defined in democratic and scientific terms, they should not have a dull moment.

We are doing our best to increase the supply of hospital supervisors, through long and short term courses, but we look forward to the return of many experienced nurses, who may choose the field of clinical supervision as their future nursing work.

Interesting People

Edith Rainsford Dick, R.R.C., has returned from active service with the army overseas to become acting director of the Nurse Registration Branch of the Ontario Department of Health. Born and educated in Milton, Ontario, Miss Dick journeyed southward for her nursing training and graduated in 1930 from the Johns Hopkins Hospital in Baltimore. After serving for a year as head nurse in her alma mater, she took her certificate in public health nursing at the University of Toronto. For the next three years, Miss Dick was engaged in

Karsh, Ottawa

EDITH DICK

administration and supervision in the Ontario Mental Hospitals. From 1935 until her enlistment, she was inspector of Training Schools for Nurses in Ontario.

In over four years service with the R.C.A.M.C. Miss Dick's experience in civilian hospitals won for her; advancement and responsibility. At the time of her release from active service she held the rank of Major (Prin. Matron) and was on duty in France. She was awarded the Royal Red Cross, first class, in June, 1944. We are happy to welcome Miss Dick back to Canada and wish her well in her new position.

Dorothy Grace Riddell, who has recently been appointed inspector of Training Schools for Nurses, Nurse Registration Branch, Department of Health, Ontario, comes of pioneering stock. Her family came from Ireland in the early days and settled in Ontario. Miss Riddell was born in Saskatchewan, received her education in Manitoba, and taught public school in that province. She chose the Toronto General Hospital as her school of nursing and graduated there in 1931. After a brief experience in private and general duty, Miss Riddell took advantage of a scholarship she had received as a graduation prize and entered the University of Toronto for the course in hospital administration and teaching.

INTERESTING PEOPLE

From 1933-37, she was a head nurse in the surgical division of the Toronto General Hospital. After two years as instructor at the McKellar Hospital, Fort William, Miss Riddell became assistant director of nurses at the Belleville General Hospital. She resigned from this position in 1943 to join the R.C.A.M.C. and saw active service in Canada and the United Kingdom, returning to Canada and civilian work early this year.

Miss Riddell has an interesting and unusual hobby. Just prior to the beginning of the war she spent nine months in England and on the continent where she learned the delicate cunning of the silversmith's craft. We hope she will find time among her new duties to pursue this intriguing avocation.

The appointment of Margaret Hope Hewett as assistant registrar of the Registered Nurses Association of British Columbia has recently been confirmed. Miss Hewett was born in China. of English parents. She attended high school in Victoria, B.C. and entered the School of Nursing of the Royal Jubilee Hospital whence she graduated in 1934. In 1942 Miss Hewett received her Bachelor of Arts degree from the University of British Columbia. Skating, tennis and badminton provide her with opportunities for vigorous activity. For the gentler arts Miss Hewett turns to art and is a member of the Art Gallery Association.

Alice Beyer Hunter has been welcomed back to assume the duties of superintendent of the Port Arthur General Hospital. Born in Kwangning, North China, Miss Hunter received her preliminary education at Belfast, North Ireland, Her high school work was taken in Havergal College, following which she completed the work for her B.A. degree at the University of Toronto. In 1927, Miss Hunter graduated from the Toronto General Hospital and for the next ten years was a head nurse in the surgical division there. In 1938, she became assistant superintendent at the General Hospital in Port Arthur. In 1941, when the Canadian Orthopedic Unit was or-



Kennedy, Toronto

DOROTHY RIDDELL

ganized by the Canadian Red Cross Society at the request of the Department of Health for Scotland, Miss Hunter was appointed matron. After nearly four years of service at Hairmyres Hospital, she has now returned to take over the administration of this Ontario hospital.

Mabel Hunter has recently retired from her position with the physiotherapy department at the Royal Victoria Hospital, Montreal, after nearly thirty years of faithful service there. A native of the province of Quebec, Miss Hunter graduated from the Royal Victoria Hospital in 1902. For ten years she engaged in private duty, then, in 1912 she undertook her training as a physiotherapist at the Orthopedic Institute in Philadelphia. In 1916 she returned to her own hospital to carry on this work and for many years has instructed the student nurses in the principles of massage. Perhaps Miss Hunter's greatest contribution was the work which she did with the returned soldiers after the first world war. Many of them have owed a debt of gratitude to her capable hands.

May Ewart, who retired from the Metropolitan Health Service, Vancouver, in February, 1945, was in the last class to be graduated by Miss Mary Agnes Snively from the Toronto General Hospital in 1910. After a year of private

duty nursing, she went to Vancouver and entered the Vancouver General Hospital as a staff nurse, and later served as a supervisor. In 1913, she was appointed as school nurse in Vancouver and, with three other nurses, pioneered in this work. In 1921, she organized the health services in the adjoining semi-urban Point Grey, covering many miles and serving many schools for eight years. When Vancouver and Point Grey amalgamated in 1929, Miss Ewart went to Kitsilano Junior High School Health Service. Here she carried on her good work for an ever-growing school population until February, 1945.

She is now retiring to her beautiful home in Caulfields, surrounded by her flowers and quietness.

Laura M. Sanders, after devoting the last twenty-four years to Child Health work in Vancouver, retired in September, 1944. Miss Sanders graduated from King's County Hospital in Brooklyn, New York, in 1916. After doing private duty nursing there for two years she came to Canada. She spent one year in Edmonton Military Hospital before going to Vancouver to join the staff of the Victorian Order of Nurses. She was in this work for only a year when she was appointed to the Vancouver City Health Department staff as a Child Welfare nurse. She became supervisor of this division in 1925 and, after the organization of the Metropolitan Health Service, was made consultant in Child Welfare to the Public Health Nursing Division.

Curing the "Focke-Wulf Jitters"

NANCY H. MACLENNAN

Editor's Note: The following abstract is published through the courtesy of the magazine, Flying. The article in its entirety may be found in their February, 1945 issue.

Instead of the traditional "rest cure", combat-weary airmen returned from war are now getting a "work cure". Hospitals once filled with long rows of beds occupied by inert and bored patients now hum with activity. Even the bedridden work. Doctors and patients alike testify that the work cure is one of the war's outstanding successes and shows excellent promise of revolutionizing many of our peacetime hospital methods.

The work cure is especially valuable in treating operational fatigue, unofficially known as "the Focke-Wulf jitters". Operational fatigue is the occupational disease of the combat flyer. It does not differ fundamentally from the nervous break-down of an overworked clerk who has a tyrannical boss or nagging wife". But there are differences.

"Each man has his flying efficiency

curve and even the best will reach a point in that curve where he will break down himself or crack up his plane. Operational fatigue is an illness made of emotional and fatigue symptoms generally manifesting itself in a state of anxiety". It is not a true neurosis, but a reaction of normal people — otherwise sound pilots or crewmen — to abnormal situations. A psychoneurotic case is actually the reverse — an abnormal person reacting to a normal situation.

Operational fatigue knows no boundaries, favors no theater of war. It occurs more frequently among bomber crewmen than among fighter pilots because bomber pilot and crew must suppress individual impulses, stick at their stations and hold their plane in position, while the fighter pilot has comparative freedom of action. Bomber pilots and crewmen have been known to complain that they never get an opportunity to fight!

Operational fatigue shows most fre-

quently during the first five missions — some airmen have "a low threshold of endurance". Another difficult period comes about two-thirds of the way through an operational tour when the accumulated effects of repeated stress may begin to tell and the flyer starts worrying about his luck running out before he gets leave.

Here's where the ounce of prevention has proven highly effective. Flight surgeons, noting fatigue signs, will pull a man off duty and send him to a rest camp away from combat for a week or so. Usually he comes back and successfully finishes his tour. The move is really a double safeguard. It saves the individual airman from a bad case of operational fatigue and it protects his fellow crewman. Men suffering from operational fatigue often weaken the morale of other airmen and may even endanger the lives of those with whom they serve. Every precaution is taken to recognize such cases and to remove them from active duty. The job is done by the flight surgeon, who recommends the change to the commanding officer. Generally, the commanding officer follows flight surgeon recommendations.

This knowledge of operational fatigue tallies with the experiences of the airmen themselves in their influence upon one another and their individual willingness to admit their fears. The flyer has learned to recognize fear as a normal reaction and the group accepts his fears as long as he controls them. He is far better able to control his fears in combat if he understands that they cause operational fatigue.

When airmen do break, operational fatigue sets in. First symptoms are deterioration of flight performance, a feeling of being "washed out". Loneliness tension, indecision, restlessness, tremors, irritability, insomnia bring a corresponding loss of weight, appetite, ability to concentrate, confidence, and zest for flying. Severe cases have terrifying battle dreams, feel no ecstasy on return-

ing from missions, suffer as from claustrophobia when flying in formation, often turn back because of imagined engine trouble. They complain of numbness and of feeling like "mechanical men".

Some men try to submerge their anxiety only to become convinced that their number is up. They worry incessantly about the state of their health. The cure is as dramatic as the cause. The job is to "unwind" the airman's psychological tension and to adjust his disturbing experiences to a rational place in his mental perspective.

Speaking generally, there are two basic steps in the treatment. The first is complete rest, insured, if necessary, by mild sedatives. The second is a mental purge, brought about by psychotherapy in which the psychiatrist interviews the patient and helps him to relieve his mind by drawing out suppressed battle fears and helping him "think his way out" of his mental conflicts.

Once the patient has recovered a normal viewpoint the services proceed to bring him back along the road of convalescence to active duty or to a normal civilian life. In this field has been applied the new "work cure" technique. If the patient is physically capable of it he is promptly encouraged to take an active part in games, therapeutic handiwork, or studies. He must do a certain amount of setting-up exercises daily and he must attend a daily discussion group on current events. Beyond this, he may choose from a larger number of useful training courses.

Such a program not only improves morale, but starts the soldier working and thinking in this field of interest and allows him to prepare himself for reassignment or, if this is impossible, to prepare for integration to civilian life.

It also works wonders in speeding recuperation. Men no longer have time to brood over personal problems or imaginary complaints. One hospital reported that as a result of the program the number of men needing sedatives to get to sleep was reduced from 44 per cent to 3 per cent. Jigsaw puzzles at bedside tables have been replaced by carburetors, tachometers, altimeters, and radio equipment. Demand for technical books at hospital libraries skyrocketed, detective story demands fell off. Classes in poster art develop pertinent posters for use at the hospital. Other patients learn to take and develop pictures, set type, run mimeograph machines, turn local publicity and develop a hospital newspaper.

Where the patient goes when pronounced cured adds to the high morale of those treated. They know that if at all possible they will be returned to their old job. Indications are that the program's scope will widen and, with the coming of peace, spread to civilian hospitals throughout the country, adding another effective technique in the eternal war against mental and physical disease and death.

R.C.A.M.C. Nursing Service

Some groups of Nursing Sisters have returned home to Canada after four or five years service overseas. Among them are some of the Sisters who were on the troop ship torpedoed in the Mediterranean in November, 1943.

The following is a list of changes, promotions and awards which have recently taken place in the R.C.A.M.C. Nursing Service.

P/M Elsie L. Riach, of No. 21 Canadian General Hospital serving with the 21st Army Group, has been mentioned in despatches.

P/M Helen G. Hewton has returned from the Italian Theatre of Operation and is now Principal Matron of No. 11 Canadian General Hospital in the United Kingdom.

P/M B. G. Herman, Principal Matron of the Mediterranean Theatre, has returned to her home in Canada on leave. She is replaced by P/M Agnes J. Macleod who was serving with the 21st Army Group.

P/M Mima MacLaren, of No. 10 Canadian General Hospital, has been appointed Principal Matron of the 21st Army Group. She is replaced by P/M Moya Macdonald of No. 7 Canadian General Hospital.

P/M Helen L. Wilson, of No. 11 Canadian General Hospital in the United Kingdom, has proceeded to the 21st Army Group in charge of No. 7 Canadian General Hospital.

P/M D. I. Riches, Principal Matron at C.M.H.Q., is on inspection of hospitals and nursing service in theatres of operation.

P/M F. G. Charlton, Principal Matron

at N.D.H.Q., is on an inspection trip of hospitals and nursing services in Military Districts No. 12 and 13 and Pacific Command.

Health of the Army

Hospital admission records show there has been a striking decline in the incidence of many diseases in this war compared with the first World War, Major General George F. Lull, U.S.A., Deputy Surgeon General of the Army, told the International College of Surgeons which met at Philadelphia in October. The pneumonia rate, he said, has dropped from 19.0 to 12.8, the measles rate f om 23.8 to 5.8, mumps from 55.8 to 6.2, scarlet fever from 2.8 to 1.6, meningococcic meningitis from 1.2 to 0.8, tuberculosis from 9.4 to 1.2 and venereal disease from 86.7 to 41.0. These figures represent annual hospital admission rates per thousand strength. Similarly the death rate from all diseases dropped from 14.1 in World War 1 to 0.6. The Army's influenza rate, which was 5.97 per one thousand in World War I, has become negligible, being less than one per one hundred thousand strength.

> Office of the Surgeon General Technical Information Division Washington, D. C.

STUDENT NURSES PAGE

General Care of Laryngeal Diphtheria when a Tracheotomy is Performed

ELIZABETH E. MACPHERSON

Student Nurse

School of Nursing, Saint John General Hospital, N. B.

Recently I had the experience of taking part in the nursing care of five cases of laryngeal diphtheria. These cases were children, only one of whom had had her tonsils removed; none had been immunized and all gave a common history of having had sore throats for five to seven days.

On admission to the hospital these children presented a grave picture. In each the membrane was so extensive that the breathing was obstructed. Retraction of the chest is typical of this type of diphtheria. It is marked by laboured, embarrassed breathing with the sternum drawn in deeply, as well as the soft tissues which are seemingly sucked in between the ribs, giving the thorax the general appearance of a skeleton. At times the breathing is stertorous. The colour is usually very cyanotic, and the patient exceedingly restless. In one of these cases the patient was in a semiconscious state when admitted.

On admission we gave a very large dose of antitoxin, from 100,000 to 150,000 units. The cardinal things to be remembered in the care of any case of diphtheria are rest and antitoxin. These cases were so far advanced that the doctor did not attempt an intubation, which is the insertion of a hard rubber tube through the mouth into the larynx

through which the patient breathes, but immediately prepared for a tracheotomy. A tracheotomy is a vertical incision into the trachea and the insertion of a double tracheotomy tube—the patient breathes through this tube instead of through the nose and throat.

We had five tracheotomies in less than two months, and of these we lost only one. In this instance, we were at a definite disadvantage from the beginning, since the child was in very poor physical condition, and did not have the stamina that is so essential. I was assigned to accompany one of the patients to the operating room, and was able to see the operation performed. It was amazing to see the relief the patient obtained as soon as the incision was made into the trachea. The mucopurulent discharge simply bubbled up and could be easily removed with suction.

In nursing these patients the important thing was to have everything close at hand. One must know where to find each article at a moment's notice. The bed was made similar to an anesthetic bed, though the operation had been done under local anesthetic. It was routine to give these patients continuous steam inhalations, so the nozzle of the steam kettle was attached to the head of the

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bed, just out of the child's reach. We selected as large a bedside table as possible, and placed it close to the bed on the more convenient side. A medicine glass with hydrogen peroxide, a medicine dropper, and a solution bowl well filled with normal saline were kept on the table and covered with a sterile towel. These were used in connection with the suction. Also on the table were tracheotomy spreaders, tubes of the correct size, obturators or pilots to fit the tubes, a pair of scissors, probe, and sterile tape. These were all sterile and wrapped in a sterile towel, ready for immediate use. The tracheotomy tubes are silver curved tubes, about two inches long, and have an inner tube which may be removed to be cleaned. The tube is held in the incision by means of tapes tied around the neck.

It had been the practice of the doctor to require that these cases be nursed by a private duty nurse but due to the shortage of nurses this could not always be done. It was necessary for a nurse to be with the child at all times; in fact in a good many instances, it took two or three nurses to handle difficult situations. It made a great deal more work for the floor nurses, but it was excellent experience which was greatly appreciated.

The suction machine was placed close to the bed, usually right beside the table. We used a small catheter with the end cut off, connected by means of a glass irrigating tip to the usual suction tube; if the mucus was very thick we removed the catheter and used only the irrigating tip, which gave much stronger suction. We usually removed the inner tube before attempting to remove the secretions by suction, though at times it was not even necessary to do that. We found the suction was much more satisfactory if we instilled a few drops of normal saline or hydrogen peroxide in the tracheotomy tube before using the suction. It softened the secretions and made them more easily removed. If the catheter became plugged we placed the

tip in the bowl of saline and allowed the suction to draw up a little of the solution. In this way the secretions were cleared from the catheter.

The inner tube had to be taken out and cleaned as often as every ten minutes in order to keep an unobstructed airway. We found a pipe cleaner and a running tap the most successful way to clean it. If the breathing was not relieved after removing the inner tube and using suction, it was necessary to summon aid immediately, have the tracheotomy tube removed and a fresh tube inserted. The doctor usually changed the complete equipment but at times the need was so urgent that the supervisor had to make the change. Many times we found the end of the outer tube completely occluded with hardened mucopurulent material or membrane.

An oxygen tank was kept beside the bed, and we made a practice of giving some oxygen for a few minutes after using the suction. In many cases it had to be given continuously. Instead of the usual face mask we used a small funnel which fitted very nicely over the tracheotomy tube.

The first two or three days after the operation the patient was given only liquids. The children soon got used to the tube in the trachea, and in very short time had no difficulty in swallowing. As soon as the breathing improved sufficiently the patient was able to take soft foods. We added a heaping teaspoon of glucose D to each glass of fruit juices and milk.

Diluted spirits frumenti with a little glucose was given as a mild sedative with fairly good effect. For restlessness we gave nembutal, grains a half per rectum, or if the respirations were fairly good a small dose of morphine was given. In almost every case the patients were given a small dose of sulfathiazole every four hours, for a few days, as a precautionary measure against pneumonia. Since the air is breathed almost directly into the lungs and is not warmed and filter-

ed as it is ordinarily pneumonia is always possible as a further complication.

If the child was well-behaved and did not move around too much, it was very handy to keep the catheter from the suction machine wrapped in a sterile towel on the pillow beside his head. Sometimes it was necessary to restrain the hands, but usually they realized that everything possible was being done to help them. We kept the opening of the tube covered with gauze at all times, at intervals using a piece of gauze moistened with saline. This helped to moisten the air that the child breathed.

Since the air expired through the tube was laden with particles of mucus, the nurse had to be especially careful to protect herself. When a patient coughed the secretions might be carried several feet in the air. Of course, the usual precautions with a case of diphtheria had to be taken and a gown and mask worn at all times.

The most critical period was from twenty-four to thirty-six hours after the antitoxin was given, and in many cases the crisis would occur about twenty-four hours after the operation was performed. At this time the membrane started to separate and it took very careful watching and nursing to keep the airway open. During this phase the pulse had to be watched very carefully, and often stimulants were necessary. The tendency seemed to be for the patient to work so hard breathing that the heart suffered under the strain.

We gave from 25 to 100 cc. of plasma intravenously each day for two or three days after the operation. The primary reason for giving the plasma was to help drain the fluid from the tissues into the blood stream, and thus lessen the edema of the tissues of the throat.

In one particular case, a little boy of three was admitted to the ward. He was a well-developed, well-nourished little fellow, but his condition was extremely serious. He had had a sore throat which had been mistaken for simple croup for several days, and so he had been given no antitoxin. His respirations were very laboured, there was considerable retraction of the chest, and his colour was very cyanotic. A tracheotomy was performed and his condition seemed to be slightly improved. About thirty-six hours after the operation, removal of the inner tube and suction failed to relieve the attacks of dyspnea and cyanosis. He had several severe cyanotic attacks which were eased by removing the complete tracheotomy tube and inserting a fresh one. After several of these attacks he became extremely cyanotic, unconscious, and ceased to breathe. The whole tracheotomy tube was removed, the suction catheter placed in the trachea, and artificial respiration administered. Coramine was given and oxygen was used continuously. When the suction catheter was removed a piece of tenacious muco-purulent membrane about two inches long and an inch wide was at the end. A fresh tracheotomy tube was inserted, he gasped and breathed, his colour returning to normal almost immediately. The child was then given a sedative and slept in long naps, completely exhausted. His respirations became almost normal, and he had no more spasms. The material withdrawn from the trachea became thin, watery mucus, and when the child became a little stronger he could eject it through the tube himself. In cases such as this we learned that the obstruction to breathing was nearly always found to be in the trachea at the end of the tube.

After the breathing returned to normal and the secretions diminished, usually from five to eight days, we closed the tube off for ten or fifteen minutes at intervals. We had several small pieces of wood made to fit the outer tube. These were sterilized, and inserted in the opening. The peg was inserted for longer periods each time, and finally the tube was corked for thirty-six hours. If this proved satisfactory, the tube was then removed, the incision dusted with

sulfathiazole powder, and a sterile dress-

ing applied.

The patient is not able to speak above a whisper until the tube is corked, and the voice will be husky for some time. It is surprising how many children fight against having the tube closed off, because it means that they have to learn to breathe all over again and they do not appreciate the effort.

After the tube has been in for five or six days there is a certain amount of danger of inflammation. As a result of the membrane peeling off, the trachea becomes larger and more normal in size, and allows the tube to move around. This will heal with scar tissue and cause

a stenosis which would necessitate further surgery. For this reason it is important that the tube be removed as soon as possible.

The length of time required for the tracheotomy wound to heal varies from two or three days to three weeks, according to the individual and the size of the incision. After removal of the tube the child should have absolute bed rest, and a light diet for about five weeks. Before discharge from the hospital the patient must have the required three successive negative nose and throat cultures. Often it takes longer to secure these cultures than in an uncomplicated case of diphtheria.

Lieutenant Governor Opens New Hospital Wing

Culminating many months of planning and labor, the new North Wing of Grace Hospital, Windsor, Ontario, was officially opened January 17, 1945, by Lieutenant Governor Albert Matthews. Hundreds of citizens joined in the celebration and enjoyed their first view of the ultra-modern, three-storey building which has been designed chiefly for the care of obstetrical patients. Souvenirs in the form of a booklet of baby verses composed by Major Christian Chapman, each tied with pink and blue ribbons, were presented to the visitors.



Staff lining-room.

The top floor is composed of a two-bed admitting room; labour rooms, three in number, and attractively furnished; three well-equipped delivery rooms, including electrically heated cots and other elaborate equipment; a doctors' sitting room, shower and bedroom, where the doctor may rest while waiting cases; a most thoughtfully arranged fathers' room complete with pleasant furnishings and a radio, where the "daddiesto-be" may pace the floor or wait in comfortable suspense for the arrival of the young guest. There are also three, threebed wards and two four-bed wards and an isolation unit. The special nurseries are divided into cubicles, four by four feet, encased in metal and glass. Only nurses are permitted near the babies, even the doctors not being allowed to enter the room. When a doctor examines a child of one of his patients, he will enter an adjoining room, "scrub up" and have the baby passed to him through a wicket. Visitors see the new babies only through a glass square. They request the baby desired through a speaking system. In this way it is expected infection will be reduced to a minimum. There are also special germicidal lamps. There are the usual working units of diet kitchen, completely fitted with monel metal sinks and



Lieut. Gov. Albert Matthews at the opening of the new hospital wing.

equipment and electric food carriers, etc. A dumb-waiter is also provided; also wash rooms, sterilizing rooms, utility rooms, etc.

A large cubicle nursery is provided on the second floor, as well as a specially constructed three-cubicle premature nursery and an isolation unit.

. The ground floor is in two sections, seventeen semi-private beds being provided for surgical cases and the 'T' part of the floor reserved for nine private obstetrical patients with its own cubicles and working units.

All the rooms are beautifully furnished with dark maple furniture, the over-bed and bedside tables being topped with formica; the colour scheme is in a delightfully soft shade of green, venetian blinds and pretty draperies are used throughout, and the floor is covered with an attractive green and black asphalt tiling.

The basement houses the superintendent's, staff, and students' dining-room. "Daring but beautiful" was the comment of an interior decorator when he saw the colour scheme of the dining-rooms. Brigadier Brett's

thought was to endeavour to have the nurses, who spend so many hours caring for the sick, forget all about it during the meal hours and she has achieved this to perfection. The staff dining-room is painted in coral with blue-topped tables and white leather chairs, large mirrors, interesting pictures, and pretty drapes. The students' dining-room is equally attractive in a lovely blue, with black-topped tables and red leather chairs and, in addition, mirrors, pictures and drapes.

A sitting room with double-decker restroom for night nurses on their hours off duty is also provided, along with wash rooms. An attractively furnished and well-stocked library is an added feature. This also includes a mobile container so that a large number of books may be taken through the hospital for the patients to make their own selection.

The accommodation is now increased to 262, including the cubicles and with the increased new facilities we are hoping to better serve the citizens of this community.

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Institutes

Twenty-two registered Sister nurses from various parts of the Dominion attended the institute on ward administration at the University of Ottawa School of Nursing. The lectures centred around the following topics: modern trends in nursing; public relations and public education; the philosophy of education as applied to clinical supervision; the ward as the laboratory to the school of nursing; ward teaching; qualifications and qualities of the supervisor; efficiency rating of the students; the auxiliary worker; the supervisor and the graduate nurse; vocational guidance and the supervisor; the undiagnosed tuberculosis case in the general hospital; and fire hazards. Round tables were conducted in Professional Ethics, and Saving in Time and Supplies. Demonstrations were given at the Ottawa General Hospital in the pediatric, obstetrical, medical and surgical wards to exemplify the various types of ward teaching. At the Strathcona Hospital for Contagious Diseases a very interesting demonstration explained isolation technique in detail and was followed by a visit through the hospital.

When the busy week came to a close the Sisters, who had participated freely and enthusiastically in the discussion, were unanimous in concluding that the supervisor should be a well-prepared executive, experienced in her special field; that the ward situation provides much stimulation for practice which has a real purpose, for learning which will be retained, and for developing important attitudes and appreciation in the student.

A three-day refresher course was re-



Representative group at the Ottowa institute,

cently held at the Institute of Public Health, University of Western Ontario through the Federal Government grant. There were forty public health nurses and sixty-five hospital nurses who attended from all parts of Western Ontario. The first day both groups attended a joint meeting. During the morning session, Dr. G. A. Wheable, inspector administrator, London Board of Education, spoke on "Basic Principles of Administration". In the afternoon Dr. C. A. Bright, Westminster Hospital, spoke on "The Pyschological Adjustment of the Returned Soldier". Following this was "The Postwar Period and Nursing" - discussions participated in by Dr. W. Sherwood Fox, president of the University, Helen Penhale, and Mildred Walker. For the remainder of the course, the group met in two sections. The public health section started with a round table discussion led by Mildred Walker on the topic "Program Planning in Public Health Nursing". Discussion was carried by Edna Moore, director, Public Health Nursing, Department of Health; Louise Steele, V.O.N., London; Edna MacIlveen, field work supervisor. "The Value and Use of the Volunteer" was discussed by Maisie Roger, executive secretary, London Council of Social Agencies. "Co-ordination of Services" was discussed by Mrs. Mabel Hatcher, epidemiologist. Ontario Department of Health, Venereal Disease Control.

The hospital and school of nursing section also had round table discussions led by Helen Penhale. The program was divided into: (a) The clinical period: Newer trends in therapeutics, Dr. H. Grant Skinner, instructor in pharmacology and therapeutics, Medical School, London; How should we interpret the term: "Supervision", Sister Marion, superintendent of nurses, St. Joseph's Hospital, London; Methods we have found to be most satisfactory in supervising students. (b) The preclinical period: Teaching the sciences, Dr. H. A. Deluca, instructor in bio-chemistry, Medical School, London; Correlating the sciences and the nursing arts, Gena Bamforth, instructor, Toronto East General Hospital. (c) What guidance does the inexperienced teachersupervisor require?: the theoretical side of

her preparation, Helen E. Penhale; the practical side of her preparation, Sister Ur-

sula, superintendent of nurses, St. Joseph's School of Nursing, Hamilton.

Book Reviews

The Hospital Head Nurse, by Mary M. Wayland, A.M., R.N., R. Louise McManus, A.M., R.N., and Margene O. Faddis, A.M., R.N., 574 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 2nd Ed. 1944. Price \$3.50.

Reviewed by Gertrude Hall, General Secretary, Canadian Nurses Association.

Changes in the hospital and nursing school, some brought about by conditions in the world at large which drastically affected their programs, made a fairly complete revision of "The Hospital Head Nurse" advisable. The "spirit" which permeated the first edition, and which did so much to focus attention on the head nurse as the "king pin" in the hospital organization, has been happily retained in the revision.

In her introductory remarks Miss Isabel Stewart, who edited the revision, states "Probably the greatest single contribution that can be made to both the nursing service of the hospital and nursing school to-day is to strengthen this indispensable corps of junior officers, to equip its members with the guides and tools they so badly need, and to inspire them with a greater confidence in themselves and in their work". This is the main purpose of "The Hospital Head Nurse."

It is evident to anyone who has any aquaintance with the work of the head nurse that important social and scientific, as well as technical, problems are involved in it. One has to dig well below the surface and reach far beyond the range of the so-called practical aspects of the subject if she is to be successful in solving these problems and is to enjoy the richer satisfactions that the position holds. No book could possibly cover all the needed information, and

especially all the basic principles, on which these solutions rest. Even the problems themselves cannot all be presented, but the reader can get some idea of their range, variety and importance from the headings and sub-headings of the different chapters.

Part I deals with the administrative functions of the head nurse and is applicable to those holding positions in hospitals with or without schools of nursing. The introductory chapter gives a general description of the position of the head nurse and what it calls for in the way of fundamental knowledge and abilities. Other new chapters in Part I deal with vitally important topics, such as basic management principles. These are clearly stated and defined, and will be welcomed by junior head nurses as a guide in the organization of their respective units

Other topics included in Part I relate to common hospital hazards, accidents and principles of supervision as applied to the direction of both professional and non-professional personel in the head nurse unit. At a time when auxiliary nursing personnel is being used so extensively as a means of augmenting hospital nursing service requirements, this particular chapter has real meaning and value and is commended for study by all those responsible for the care of patients.

Additional techniques, especially in relation to the management of the nursing service, have been suggested, described and illustrated, and there is also an elaboration of the factors affecting care, including an outline of the newer method of calculating the average bedside nursing hours. Head nurses will find this chapter helpful in estimating the nursing personnel requirements for their respective units.

Part II has been completely re-written

to include new material and to show the newer emphasis upon the clinical education program, the student's responsibility for learning, and the head nurse's responsibility as clinical teacher for directing the student's progress in her unit.

Illustrations of a possible plan for the division of responsibility for teaching the disease conditions occurring in six medical and six surgical units in a large hospital, also include a clinical content and head nurse Teaching Plan. Emphasis has rightly been given to the importance and method of teaching patients.

Chapter XXV deals with the appraisal of nursing ability and recording of the student's experience and progress. The basis and methods of appraisal are clearly and carefully outlined and are commended for study by hospital and public health nurses. There are excellent suggestions for group activity on this much-needed subject.

Part III considers the satisfactions and opportunities for creative service and personal satisfactions inherent in the position of head nurse. Excellent and fairly extensive bibliographies are given at the end of each chapter.

This book could be read with profit and pleasure by all those interested and associated with nurses and nursing.

Medical Care of the Discharged Hospital Patient, by Frode Jensen, M.D., H. G. Weiskotten, M.D., and Margaret A. Thomas, M.A. 94 pages. Published by The Commonwealth Fund, 41 East 57th St., New York City 22. 1944. Price \$1.00.

Reviewed by Edith Pringle, Inspector of Hospitais and Institutions, B.C.

This book outlines and reports upon an experimental study undertaken by the Syracuse University College of Medicine. There are new ideas clearly set out which give information and data regarding the relationships of the hospital, the doctor and the social worker to the patient as a person; a cautionary note is given against a tendency to stress disease rather than the patient suffering from disease. Realizing that the major emphasis in a medical care program should be placed upon the needs of the individual patient and that there are other features of the program that should be co-ordinated with these needs, the author has in the report shown how this was actually accomplished at the University Hospital.

The descriptive report tells of the manner in which the experiment was conducted, discusses the various problems met, and evaluates the results of the study. The purpose of the experiment was to provide a service as well as conduct a study. One purpose was to provide a particular kind of medical care that had been lacking. The study was undertaken to inquire into "The value of continuous medical care to patients, who are economically unable to employ a family doctor, by a competent physician who is familiar not alone with the patient's illnesses but also with the relevant emotional and social economic fac-

The appointment of an extra-mural resident on the medical staff of the University Hospital and of the College of Medicine was the first step, followed by arrangements for co-operative facilities for hospitalization, medication, diagnostic procedures and social case work in the local health and social agencies. There were 902 patients served during the experimental program of which 85 per cent were chronically ill and 15 per cent acutely ill. The volume of work necessitated the appointment of a fulltime social investigator to provide social data for research purposes but the actual social case treatment was left to the hospital social service department staff and to public and private agencies. Chapter 4 deals with the Physician-Patient relationship and Chapter 5 with Medical Social Work. There are many case illustrations. Doctors and social workers will find this study easy to read, interesting, containing information of value to all those concerned with medical social problems arising between the hospital and the home.



MAY. 1945

NEWS NOTES

ALBERTA

CALGARY:

The following officers were recently elected by the Calgary General Hospital Alumnae Association: honourary president, A. Hebert; honourary vice-president, J. Connal; honourary members, M. Moodie, A. Casey, N. Murphy; past president, Mrs. G. Macpherson; president, Mrs. A. McIntyre; vice-presidents, Mmes E. Hall, H. Holland, N/S L. Kautz, H. Fisher; recording secretary, Mrs. J. Eakin; corresponding secretary, Mrs. W. Kemp; treasurer, Mrs. W. Kirkpatrick; committee conveners: refreshments, Mrs. W. MacMillian; entertainment, Mrs. T. Hall; membership, Mrs. E. Connolly; ways & means, Mrs. A. McGraw; visiting, Mrs. C. Boyd; overseas nurses auxiliary, Mrs. T. Valentine; press. Mrs. C. Glover; additional members, Mmes T. O'Keefe, A. Hammill, Miss I. Robertson.
Our Ice Carnival was very successful, the net proceeds being \$2504, 25 per cent of which we used for war efforts and 75 per cent for our hospital. We are sending two

Our Ice Carnival was very successful, the net proceeds being \$2504, 25 per cent of which we used for war efforts and 75 per cent for our hospital. We are sending two parcels a year to each of our thirty nurses now serving overseas. For one week each year we sponsor the Red Triangle Hostess Club for the armed forces. Our members are supporting the Red Cross blood donor clinic. Mrs. Parks has been doing the laboratory work for the clinic since it started, and we are very proud of her voluntary

contribution.

BRITISH COLUMB!A

. NEW WESTMINSTER:

Royal Columbian Hospital:

With the aim of setting up a bursary for graduates of the Royal Columbian Hospital, the Alumnae Association entertained at a St. Patrick's Day tea. Mrs. J. A. McDonald was the convener and Mrs. W. E. Gutteridge was in charge of refreshments, while the dining-room was looked after by Mrs. G. Brine and the program by Mrs. D. Matheson. The president, Mrs. C. M. Purvis, with Mrs. J. McDonald and C. E. Clarke, received the guests, and Mmes W. Mott, D. Trumbull, C. D. Peel, H. B. Thompson, R. E. Mitchell and T. Amy poured tea. Contributions were received by Mrs. G. Grieve, while in charge of the drawing were Mmes E. Jarvis and E. M. Phillips.

ROSSLAND:

A reorganization meeting of the Rossland

Chapter, R.N.A.B.C. was held recently when the following officers were elected: president F. McLean; vice-president, Mrs. J. McAllister; secretary, Mrs. W. Stevens; treasurer, Mrs. R. Williamson; program convener, Mrs. R. Thompson; social convener, Mrs. K. Scatchard. Future plans of activity were discussed and a social hour followed, refreshments being served by Mrs. R. Morin, M. Klein, and O. Hengle.

TRAIL:

The following officers were recently elected by Trail Chapter, R.N.A.B.C.: president, Mrs. K. Gordon; vice-president, Bernice Quick; secretary, Betty Kirkpatrick; treasurer, Mrs. Betty Kennedy.

At a recent meeting the retiring president, Dorothy Paulin, gave an interesting resumé of social activities and work accomplished during the past year. In February Alice Wright, registrar of the R.N.A.B.C., paid us a visit on her tour of training schools, and cleared up many points regarding registration in wartime.

Vancouver General Hospital:

The annual banquet of the Alumnae Association was held recently when the guests of honour were the members of the graduating class of 1945. Classes from 1907 were represented among the 250 present.

graduating class of 1945. Classes from 1907 were represented among the 250 present. Following the toasts there was a clever skit by the senior students in nursing at U.B.C. It represented the dreadful dream of a student nurse conducting her first child welfare clinic. An excellent travelogue in colour, "South of the Border", was later presented. Credit for the arrangements is due to Mrs. Mary Mercer (Dunfield) and her committee.

ONTARIO

DISTRICT 4

HAMILTON:

At a well attended regular meeting of the Hamilton Chapter, District 4, R.N.A.O., with H. Snedden, the chairman, presiding, the guest speaker was Jeanette Merry, education officer of the Queen's Institute of District Nursing, London, England. Miss Merry conveyed the appreciation of the British nurses for the help given them during the blitz by the Canadian nurses. The Queen's nurses number 4600 in the British Isles, with an annual recruitment of 600 pre-war and 400 during the war. The



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THE RYERSON PRESS
TORONTO

Ministry of Labour and National Service was given power to call up nurses in certain age groups for nursing in civilian hospitats and services, thereby recruiting many married and part-time nurses. At the present time the government has under discussion the matter of pensions for British nurses. Miss Leleu moved a vote of thanks to Miss Merry for her interesting insight into life in wartime Britain. A social hour followed when Misses Chisholm and Scheifele presided at the tea table.

WELLAND:

As we no longer have a training school in Welland, we have reorganized our Alumnae Association and it is now called the Welland Graduate Nurses Association. This means that any registered nurse may now become a member. We have sixty-five members so far, including private duty, industrial, and general duty nurses. Last winter we conducted "A Country Fair" where we sold novelties, aprons, knitted goods, candy and home-made baking, which was all donated by the members and their friends. We also had two rooms of bingo and sold refreshments. We realized approximately \$350. With our funds we are going to help the nurses registry, and keep our nurses alumnae ward in the hospital well supplied. We have donated \$50 to the Red Cross, and also contributed to the I.O.D.E. for books for the services.

The nurses are co-operating splendidly and all seem very enthused. We try to have an interesting speaker at each meeting and have a social hour later.

DISTRICT 5

TORONTO:

The following report is submitted by Mary McLaughlin, president of the Inter-School Student Nurses' Association of Toronto.

The Inter-School Student Nurses' Association of Toronto had its beginning in the early part of 1937. At that time members of the Centralized Lecture Course Committee felt that there was a real need among the students for broader horizons and a more mutual relationship. Hence the idea of an inter-school organization was born. Although the seed originated with the higher powers it was to be planted, grown and bear fruit among the students themselves. It was to be essentially a student organization — giving scope to their imaginative and creative powers.

The opening of the season of 1944—45 found us weak and struggling. The absence of a constitution was readily rectified and then we started to enlarge and give more body to our year's program. An event for every month was planned and in some instances there were two. These were athletic and social in emphasis. In the realm of athletics we have participated only in teu-

nis and basketball but in future we hope to add swimming to the list. At our social gatherings we have sought for the most part to dip into those spheres of culture outside

our own profession.

Last Fall we were privileged to hear from Dr. E. J. Pratt, one of Canada's fore-most poets. Lt. Col. A. C. Neill, on a brief tour of duty from England, brought us some of the highlights of wartime nursing in England, Africa, and Italy. The January meeting took the form of a musicale. In February we held our annual party and at our annual mass meeting Florence Emory spoke to us on "Opportunities in Nursing — Present and Future". A dinner, in honour of our nine graduating classes, closed our year in April.

Business meetings have been held each month to make the necessary arrangements for these gatherings. Our council consists of twenty-seven representatives — three from each school. From this council we elect an executive consisting of a president, vice-president, secretary, treasurer and conveners of social, athletic and publicity com-

mittees.

St. Michael's Hospital:

The quarterly meeting of St. Michael's Hospital Alumnae Association was neid recently when the following officers were elected: president, M. Hunt; vice-presidents, M. Regan, L. Riley, M. McGarrell; treasurer, N. O'Connor; assist. treasurer. E. Cooper; recording secretary, M. Doherty; corresponding secretary, Mrs. Forrester; councillors, K. Boyle, D. Murphy, K. Meagher; conveners: active membership. L. Huck; associate membership, Mrs. M. Meaden; representatives to: public health, Meaden; representatives to: public health, M. Tisdale; nursing education, G. Murphy; Local Council of Women, Mrs. Scully; press, E. Darrach; plan for hospital care, V. Murphy; editor, "The News", K. Boyle; assist. editor, Mrs. M. Neville. The Alumnae is very pleased to have Rev. Sr. M. Margaret, former honorary president, back with us in the same capacity after an absence of twelve years. absence of twelve years.

Margaret guest speaker, (St. Michael's Hospital, 1932, and course in public health nursing, University of Toronto) gave an interesting account of her experiences overseas. Miss Hunt has recently returned after four and a half years service in England, North Africa,

Sicily and Italy.

Special mention was given to Doreen Murphy for the successful project, instigated and convened by her, in aid of the scholarship fund. The post-graduate education of three students will be financed. Two of these nurses will be Alumnae members of two years standing and the other a member of the graduating class.

DISTRICT 8

annual meeting of District



Keep them nealthy-let Baby's Own Tablets Keep them nealthy—let Baby's Own Tablets help you. Pleasant, simple tablet triturates, they can be safely depended upon for relief of constipation, upset stomach, teething fevers and other minor aliments of babyhood. Warranted free of narcotics and opiates. A standby of nurses and mothers for over 40 years.

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Physicians' and Surgeons' Bldg., 86 Bloor Street, West, TORONTO 5. WINNIFRED GRIFFIN, Reg. N.

R.N.A.O., was held recently in Ottawa. The guest speaker was Mr. Walter S. Woods, Deputy Minister of Veterans Affairs. Mr. Woods gave an interesting talk on post-war rehabilitation plans, stressing the fact that the nursing profession offers a wide and varied field of opportunity for women serving in the armed forces.

for women serving in the armed forces.

The retiring secretary-treasurer, Joan Stock, stated that under the convenership of Sr. Madeleine of Jesus the membership has risen in the district to 703, an increase of 76 over the past year. The financial report showed that the expenditures of the association totalled \$134.25, against a total income of \$841.50, which was forwarded to Toronto. The bank balance for January amounted to \$198.32. It was announced that W. Cooke, K. McIlraith, and J. Stock had been appointed to attend meetings of the post-war reconstruction meetings of the post-war reconstruction committee of Ottawa-Hull.

The following officers were elected for the ensuing year: chairman, W. Cooke; vice-chairmen, M. Robertson, K. McIlraith; secretary-treasurer, Mrs. B. Taber; councillors, Sr. M. Evangeline, I. Allan, V. Belier, M. Hall, G. Moorhead, E. Graydon; chairmen: Pembroke Chapter, E. Cassidy; Cornwall Chapter, Sr. M. Mooney.

At a recent meeting of the Hospital and

At a recent meeting of the Hospital and School of Nursing Section, District 8, R.N.A.O., the following officers were elected: chairman, M. Thompson; vice-chairman, Sr. Helen of Rome; secretary-treasurer, E. McIlraith.

OUEBEC

MONTREAL:

Children's Memorial Hospital:

Madeleine Flander recently gave a refresher course in pediatrics at Charlottetown, P.E.I. Ella Vey, a former member of the staff is now at the Brome-Missisquoi-Perkins Hospital, Sweetsburg, Jeannette Soullière. who has recently taken a pediatric course in Detroit, is now on the staff. Hilda Nuttall has recently returned from a short course in ward teaching and administration in Toronto.

SASKATCHEWAN

MOOSE JAW CHAPTER:

At a recent meeting of the Moose Jaw Chapter, interesting letters were read from three nursing sisters serving overseas: Nursing Sisters Grace Canning, Wilhel-mina H. Bergman, stationed at No. 21 C.G.H. and J. A. Havorke at No. 16. C.G.H. They were very grateful for the parcels sent at Christmas by the Chapter. Several letters of acknowledgement have also been received from N/S Meadows who is serving with Col. Young's unit overseas.

with Col. Young's unit overseas.

Peggy Ogilvy left Moose Jaw recently to take a position in Edmonton at the University Hospital. Prior to this, Miss Ogilvy was doing private duty nursing in Moose Jaw and assisting with the work of the Red Cross blood domor clinic, Mrs. Repaye will take over the duties of the sick and visiting committee which was vacated by Miss Ogilvy. The Chapter regrets the loss of two members, Mrs. Selvig and Mrs. Flack, their absence being felt keenly by the ways and means committee convened by Mrs. Helena Butler. Mrs. Selvig is now in Shaunavon and Mrs. Flack has accepted a position at the Weyburn General Hospital.

Kristie Jamieson was guest speaker at the meeting of the University Women's Club recently. Miss Jamieson had attended a conference on Venereal Disease control and gave her listeners the benefit of her experience in a well organized talk. Discussing the "problem" and the "program", the speaker gave information on the Four Sector front.

Mrs. Alta Tait reported recently a paidup Chapter membership of 52.

The student nurses of the Moose Jaw General Hospital were "at home" recently to all graduate nurses of that school. The "entrance fee' for the graduates was a cup and saucer which will be used to equip the new snack bar in the residence. Betty Fisher acted as mistress of ceremonies for the evening and gave the roll call. A presentation was made to the three senior graduates present: Mrs. C. Barnes (1915); Mrs. J. Droppo (1916); Mrs. H. Gill (1917). A delightful evening was spent playing whist, bridge and bingo, with incidental music provided by Gwen Orrell. A lunch was later served by the students.

Marguerite Wilson, who has spent the past year in Bermuda, is visiting in Moose Jaw.

REGINA CHAPTER:

A very successful membership tea was recently held by the Chapter.

The Regina and Moose Jaw instructresses meet monthly at either Regina or Moose Jaw to "iron out" some of their daily problems and to help them raise their own standards of teaching.

Rev. Sr. Krause recently left the Regina Grey Nuns' Hospital. Rev. Sr. Murphy, who has been at St. Boniface, is the new superintendent of nurses. N/S's Harlton, Townsend and Moodie left the city recently for duty with the R.C.A.M.C.

SASKATOON CHAPTER:

At the annual meeting of the Saskatoon



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Nugget is also available in Black and all shades of Brown.



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Applications are invited for the combined position of (1) Executive Secretary & Registrar, Manitoba Association of Registered Nurses; and (2) Adviser to Schools of Nursing in Manitoba.

Applications should be submitted on or before June 15, 1945, and should

provide the following data:

(1) Academic and professional qualifications; (2) Experience as a graduate nurse; (3) A certificate of health. Apply to:

Selections Committee, Manitoba Association of Registered Nurses, 214 Balmoral St., Winnipeg, Man.



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Mouth care is a habit; Mouth health the result.

Chapter the following officers were elected for the coming year: president, M. Jarvis; vice-presidents, I. Mandin, L. deFaye; secretary, L. Willis; councillors, M. Chisholm, Rev. Sr. St. Croix, R. Smith, E. James, Mrs. C. Thompson, M. E. Grant. Twenty-two members were present and heard annual reports from the chairmen of the three sections, the registrar and treasurer, and conveners of the social and program and registry committees. It was noted that the Chapter is in an excellent financial position. Plans were made to hold the annual Vesper Service in St. John's Cathedral on May 13 in conjunction with the Nursing Sisters' Association.

Plans have also been made for a special meeting of nurses so that they may have the opportunity of meeting G. M. Hall, general secretary of the C. N. A., and M. E. Kerr, editor of *The Canadian Nurse*.

Joan Witney and Edna Larmour, formerly of the Saskatoon City Hospital staff, have joined the R.C.A.M.C. and are stationed in Eastern Canada. Both are graduates of the S.C. H. the former also holding the B. Sc. in Nursing from the University of Saskatchewan. Lucy D. Willis has accepted an appointment as instructor in nursing arts at the S.C.H., having been on the staff for some time as clinical instructor. Two recent appointments to the operating room staff of the S.C. H. are as follows: J. Campling has accepted an ap-

pointment as supervisor; A. Phillips has accepted a position on the general staff.

YORKTON CHAPTER:

Yorkton Chapter, District 4, has recently been approved by the Council of the S.R.N.A. as an authorized Chapter. It is the first Chapter to be formed in District 4. The following are the officers for 1945: president, Mrs. D. Logan; vice-president, Mrs. T. Stewart; secretary, M. S. Langstaff; treasurer, K. Francis; committee, Mmes J. Young, G. Sinclair.

The Chapter is particularly interested in contributing to some community enters

The Chapter is particularly interested in contributing to some community enterprise. At present its members are helping with the making of dressings at the Yorkton Hospital. The Chapter is interested too in the newly-formed "Youth Organization" in Yorkton and is making inquiries as to what part they may take in assisting this

worthwhile endeavour.



WANTED

General Duty Nurses are required for an 80-bed general hospital in Southern Ontario. Salary: Minimum, \$85; after six months, \$90; after one year, \$95. Full maintenance. Eight-hour day; six-day week. All graduate staff. Two weeks paid vacation. Two weeks sick leave. Free hospitalization. Apply in care of:

Box 3, The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P.Q.

WANTED

Applications are invited for the position of Provincial District Nurse in the Province of Alberta. Districts located in rural areas. Cottage, water and fuel supplied by community. Salary: Minimum of \$1500 per annum, plus Cost of Living Bonus. Sick leave. Annual vacation provided after one year's service. Apply to:

Miss Helen G. McArthur, Superintendent of Public Health Nurses,

218 Administration Bldg., Edmonton, Alta.

WANTED

General Duty Nurses are required for a modern 220-bed hospital. Eighthour day; six-day week. Pleasant working conditions. Salary begins at \$95 per month; increased to \$100 after six months; plus meals and laundering of uniforms.

Opportunities for further advancement. Apply to:

Superintendent of Nurses, Jewish General Hospital, Montreal 26, P. Q.

WANTED

A Nurse is required for Staff work with the Department of Health, St. Catharines, Ontario. Certificate in Public Health Nursing necessary. The annual salary is \$1400, or higher, depending on qualifications. Apply to:

Supervisor of Nursing, Department of Public Health, St. Catharines, Ont.

WANTED

An Operating Room Supervisor, with post-graduate experience, is required for the Victoria Public Hospital. Apply, stating qualifications, experience, and salary expected, to:

Superintendent, Victoria Public Hospital, Fredericton, N.B.

WANTED

Applications are invited for the positions of Assistant Night Supervisor, Obstetrical Night Supervisor, and Medical Supervisor in a 200-bed hospital with a School of Nursing. Apply in care of:

Box 4, The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P.Q.

WANTED

An Operating Room Supervisor and a Dictitian are required for the Glace Bay General Hospital. Apply, stating qualifications, experience, and salary expected, to:

Superintendent, Glace Bay General Hospital, Glace Bay, N.S.

MAY, 1945

WANTED

Vancouver General Hospital desires applications from Registered Nurses for General Duty. State in first letter date of graduation, experience, references, etc., and when services would be available. Eight-hour day and six-day week. Salary: \$95 per month, living out, plus \$19.92 cost of living bonus, plus Note: The Hospital can obtain exemption for accommodation from Emergency Shelter Administration. The nurse is not exempt, excepting through employ of Hospital. Apply to:

Miss E. M. Palliser, Director of Nurses, Vancouver General Hospital,

Vancouver, B. C.

WANTED

General Duty Nurses, registered or graduates, are required for the Lady Minto Hospital. The salary is \$90 and \$80 per month, with full maintenance. Apply, stating full particulars of qualifications, to:

Lady Minto Hospital, Cochrane, Ont.

WANTED

Applications are invited immediately for Staff positions with the Department of Public Health and Welfare, Halifax, Nova Scotia. Apply, stating qualifications, in care of:

Supervisor of Nurses, Department of Public Health & Welfare, c/o Dalhousie Clinic Bldg., Halifax, N.S.

WANTED

An Instructor of Nurses is required for the Prince Edward Island Hospital. The position is open September 1, 1945. The salary is \$100 per month, with full maintenance. Apply to:
Superintendent, P.E.I. Hospital, Charlottetown, P.E.I.

WANTED

Graduate Nurses, Instructress of Nurses, and a Dietitian are urgently required for the Highland View Hospital in Amherst. Apply to:

Highland View Hospital, Amherst, Nova Scotia.

WANTED

A Night Supervisor and Night Assistant are required for the Cornwall General Hospital of 75 beds. 6 night week; alternating week 5½; 3 hours off duty other nights. Apply, stating experience and qualifications, to:

H. C. Wilson, Supt., Cornwall General Hospital, Cornwall, Ont.

WANTED

A Registered Nurse is required as Night Supervisor; three Registered nurses are also required for General Staff Duty. Eight-hour day and six-day week, with full maintenance. Apply, stating salary expected, to:

Superintendent, Shriners' Hospitals for Crippled Children, Montreal Unit, Montreal 25, P. Q.

WANTED

A qualified Instructress and a Surgical Supervisor are required immediately for a 120-bed hospital. Apply, stating qualifications, experience, and salary expected, to:

Superintendent, General & Marine Hospital, Owen Sound, Ont.

WANTED

A Science and Practical Arts Instructor is required for the Victoria Hospital, Prince Albert, Saskatchewan, for September 1, 1945. The salary is \$150 per month, with full maintenance. Four weeks vacation and four weeks sick leave with pay each year. Apply, stating particulars, age, and qualifications, etc. to:

Mrs. J. S. Harry, Supt. of Nurses, Victoria Hospital, Prince Albert, Sask.

General Duty Nurses are required immediately for the Toronto Hospital for the Treatment of Tuberculosis. Eight-hour day; six-day week; good living conditions. The salary to start is \$85 per month. Apply to:

Superintendent of Nurses, Toronto Hospital, Weston, Ont.

WANTED

Two Registered Nurses are required for permanent Night Duty. The salary is \$90 per month, plus full maintenance. One full night off each week. Apply to:

Superintendent, Brome-Missisquoi-Perkins Hospital, Sweetsburg, P.Q.

WANTED

An Assistant to the Superintendent of Nurses is required by the Sherbrooke Hospital. Applicants must also be able to assist with the instruction for a rapidly-expanding English School of Nursing. Position available immediately. Apply, stating qualifications, experience, and salary expected, to:

Superintendent of Nurses, Sherbrooke Hospital, Sherbrooke, P. Q.

WANTED

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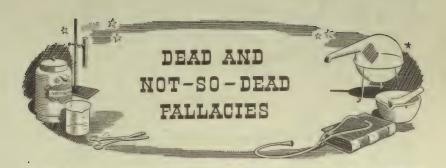
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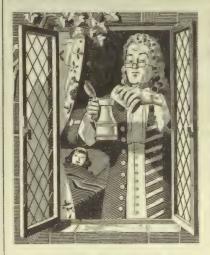
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He was a member of the Council for Assiniboia in 1868, and took part in the provincial convention which met a year later. When Manitoba became a province, he represented St. Paul's Parish in the Legislative Assembly and was made Speaker. In 1870 hé was chosen a candidate for the Dominion Government.

For a number of years Curtis Bird was coroner for the District of Assiniboia, and in 1870 he was appointed to this office in the Provisional Government. While on a trip to England in 1876 he contracted pneumonia and died.

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Reader's Guide

The cessation of hostilities in Europe will bring rapidly into focus the numerous plans for the rehabilitation of the men and women of our armed forces which have been discussed widely in the past few months. To clarify our thinking, both as individuals and as members of community groups, and to place the emphasis in our planning where it belongs, we recommend a careful study of "Return from War" by Dr. D. Ewen Cameron. He is director of the Allan Memorial Institute of Psychiatry in Montreal and is thoroughly familiar with the types of problems which are likely to arise in families following long periods of separation under particularly difficult circumstances.

Our guest editor this month, Lillian E. Pettigrew, president of the Manitoba Association of Registered Nurses, is a public health nurse who has gone back to her home school, the Winnipeg General Hospital, as health instructor and consultant to the student nurses. Miss Pettigrew has an intimate knowledge of present-day nursing problems and describes the trends in Manitoba.

The writings of Dorothy Deming have long been familiar to the public health nurses of Canada through the Public Health Nursing Journal. It is a privilege to present here the paper which she gave at the thirty-third annual meeting of the Canadian Public Health Association in Toronto last autumn. This paper was published in the January, 1945, issue of the Canadian Journal of Public Health and is reprinted with their kind permission. Miss Deming is public health nursing consultant, Merit System Unit, of the American Public Health Association.

A new plan for the affiliation of student nurses, in order that they may learn by actual experience the modern practices for the prevention and care of tuberculosis, has been developed by the Division of Tuberculosis Control of the Provincial Board of Health in British Columbia. Ferne Trout, B.A., B.A.Sc.,

who is student supervisor with the Vancouver Unit, discusses the scope and limitations of this important stride in nursing education.

Margaret Pringle was appointed director of Nurse Placement Service when the New Brunswick Association of Registered Nurses decided to launch this type of program last year. From the vantage point of several months' experience, Miss Pringle surveys the accomplishments to date and indicates the plans for future developments.

Have you ever been nurse at a summer camp? Lilian MacKinnon had a most interesting time for eight weeks at Camp Lewis, up in the Laurentian Mountains. The camp was organized and directed by the Boys' Association of Montreal for the purpose of giving under-privileged lads two weeks vacation. She found she had never a dull moment.

Edith M. Pullan gives us a brief insight into one of the common causes of mental disturbance brought about by the indiscriminate use of certain of the patent medicines. Miss Pullan is a supervisor at the Provincial Mental Hospital, Essondale, B. C.

Childhood is about the most obvious thing in the world. Everybody has experienced it, yet many of us when we are grown to maturity have forgotten what it means to be a child. Some adults are fond of children, some are not; some understand them, some misunderstand them; some expect the best of them, some expect the worst; some are happy and friendly with them; some are uncomfortable and ill-at-ease in their company. Every nurse has had some courses in the psychology of childhood, and the care of children when they are ill. Linda Robertson gives us a brief insight into the feelings and responses of the youngsters when they come to hospital which should help us to comprehend what a strange world the hospital is to them.



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-BOYD, J. D.; J. A. D. A., 30:670, May, 1943.



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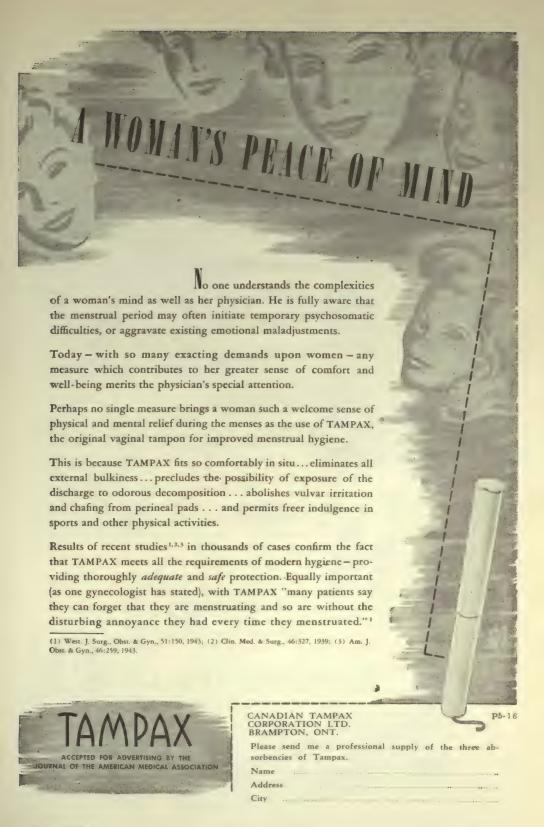


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CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-ONE

NUMBER SIX

JUNE 1945

Dealing in Futures

A state of emergency, such as war, always tests the strength and focuses the weaknesses of any social organization. It is not a coincidence that the Manitoba Association of Registered Nurses has been faced at this time with the necessity of planning for the future of the profession by solving matters of major concern at the present.

Recently, the Manitoba Legislature passed an Act which provides for the training, examination, licensing and regulation of practical nurses. It is realized that the community has need of both professional and non-professional nursing services if it is to receive all forms of care. The non-professional services rendered to the public will be standard-dized and controlled by this legislation to a greater degree than ever before. Therefore it is timely to direct the thoughts of professional nurses to the obligations that such legislation implies:

1. That the practical nurse has a legal

status and that she has a recognized essential service to offer to those in need of non-professional care.

2. That professional nurses shall be prepared and ready to serve the community in the ever-expanding spheres of professional service; that the worthiness of the registered nurse's service will be tested by the skill and altruism that are the prerequisites of those who claim to be professional.

3. That professional nurses will require more and better educational preparation for the fulfilment of the services that will be expected by the community, the Province and the Dominion.

Through the courteous offices of the Minister of Health and Public Welfare an amendment to the Act of Registration was passed by the Provincial Legislature in recent session. The amendment provides the Board of Directors with greater discretionary powers in granting registration to those whose qualifications are equivalent to the requirements of the Act but which do not conform specifically with those requirements.

JUNE, 1945

Some months ago, under the leader-ship of the assistant executive secretary, Miss Frances Waugh, student nurses from all schools of nursing in the province were organized with the aim of stimulating a vital interest in organized nursing provincially, nationally and internationally. The Manitoba Student Nurses' Association is unique in that, as yet, it is the only provincial student nurses association of Canada. It is a flour-ishing body conducting its meetings in a truly professional way and stimulating an enthusiastic interest in all phases of professional growth.

Since September, 1943, the School of Nursing Education established within the University of Manitoba, has been subsidized by a portion of the federal grant received by the Manitoba Association of Registered Nurses. Convinced of the imperative need for the continuance of the School on a permanent basis, a committee appointed by the Board of Directors of the M.A.R.N. has been active in devising ways for ensuring this permanency. An appeal has been issued to every member of the Association to interpret and support the efforts that are being made to place the School on a sound foundation. Nurses are keenly aware of the need in Manitoba and Western Canada for the facilities provided by this School. They can provide the impetus that is necessary to assure the public support of this project.

With funds available from the federal grant, the Provincial Placement Service

was established in August, 1944. Recognizing the increasing diversification in nursing practice and the essentiality of an avenue through which users of nursing service may be supplied with the services they require, plans for the continued financial support are being considered. Bearing in mind that it is serving community, institutional, and individual needs, it is more logical than visionary to presume that in future community support may be given to this service.

In conclusion, in the words of Professor Eduard C. Lindeman (A.J.N., Dec. 1939) we see the beam of human need which is the motivating force of all professional service: "The professions exist primarily for the purpose of aiding man in his adaptations. The professional person enters the human situation when adaptation has somehow failed, or when men are engaged in planning for their future welfare. The importance of the professions increases in direct proportion to the extent of man's attempt to alter his environment for the purpose of meeting his needs". Have Manitobans, have Canadians ever been engaged in planning for their future welfare in greater earnestness? Has the beam of social need ever beckoned more brilliantly for professional nursing service?

LILLIAN E. PETTIGREW
President
Manitoba Association
of Registered Nurses.

Preview

The whole field of psychiatry has taken on new meaning in recent years. A symposium on the place of mental hygiene and mental nursing in the reconstruction period was a feature of the program at the recent convention of the Registered Nurses Association of Ontario. We are privileged to share with our readers the stimulating papers prepared by Dr. G. H. Stevenson, Laura W. Fitzsimmons, Hilda Bennett and Eileen Cryderman.

Return from War

D. EWEN CAMERON, M.D.

The most obvious preliminary statement to be made is one concerning the confusion which exists regarding the whole matter of the return of men to civilian life. This confusion is only in part administrative in origin. In large measure it arises from the fact that the series of problems created by return from war is serving in increasing measure as an outlet for much of the muddled antagonisms, hostilities and frustrations provoked by the war in citizens, both in the armed forces and outside. These emotional reactions are arising in consequence of the forced separation from homes and jobs; they arise from the real and apparent injustices consequent upon this; from the feelings of frustration on the part of those who wish to be in the services and from the guilty feelings of some of those who have not gone; from the apprehension of those who fear the return of the men who did go, and from the hostilities of those who expect to be displaced from their jobs and from their places in the family group by the returned man.

Nonetheless, a central core of problems remains once we have winnowed off the confusions and misapprehensions. To further this process of winnowing off let me say this—that one of the misconceptions which has made the whole problem appear to be even more complex and more difficult than it actually is arises from the confusion concerning the term, "Neuro-psychiatric casualty." The public has been deeply concerned and rightly so over the very large number of men who are rejected for neuropsychiatric reasons, and over the large number who are later discharged for similar reasons. For a great many people mental ill-health was something that the other fellow had, and particularly the other fellow who was being looked after in one of the Provincial Hospitals.

War, with its imperative demands for excellence in personality and performance, has set our standards of selection so high that a great many men and women, whose mental health and efficiency were sufficient for them to carry on in civilian life, have been excluded as not good enough for army life; a great many men and women, for the same reasons, once admitted to the armed services, have not been able to carry on. There is no doubt that in the long run this will be most salutary in allowing us to see that the amount of mental ill-health and impaired efficiency which exists among us is very great and, at the same time, that the numbers who actually require care in Provincial Hospitals represents quite a small proportion of those whose effectiveness is decreased, but who do carry on under ordinary circumstances or who can carry on with varying degrees of medical assistance. Indeed, the great majority are not aware that their difficulties and their relative ineffectiveness are due to poor mental health. Public opinion has not vet identified those forms of ill-health. Public opinion in the nineteenth century had not yet identified the forms and range of low-grade chronic ill-health due to inadequate nutrition, to focal infections, to poor industrial and housing conditions.

Salutary although this forcible impingement of these facts upon our minds will be, we must be clear-sighted in dealing with the immediate problem of the men returning from war. The most succinct statement which can be made is that neuro-psychiatric casualty is not synonymous with civilian inadequacy. Actual experience has shown that the majority of men discharged for neuro-psychiatric reasons during this war have returned to work without the need of special provision. This large group is

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comprised, in part of course, of men and women who have some degree of intellectual handicap which prevents them from meeting the high demands for skill and precision now required in many branches of the armed services. Their intellectual limitations, however, do not prevent them in any way from carrying out useful and necessary tasks in civilian life. It is comprised also of people who have degrees of emotional instability which do not allow them to face the hazards and dangers of war. It is comprised of those who have been brought up in over-protected homes who cannot stand the long separation from their families, but who are quite capable of fitting back into the places which they formerly occupied in civilian life, or at any rate, become capable of doing so within a very short period of time and with the minimum of assistance.

It has been found that the number of men and women discharged for neuropsychiatric reasons who feel under any necessity to seek neuro-psychiatric help and guidance, even where this is provided in the most readily accessible and acceptable form, is quite small. When I say that the proportion is small I do not in any way wish to give the impression that the actual number is small, save in relationship to the total. There is a great need for increasing the facilities for the care of that group of men and women discharged for neuro-psychiatric reasons who will need treatment and, in some instances, continued treatment.

Having separated out from our central problem this considerable number of men and women who were unfitted for military life but not for civilian life, I would like to perform a second operation and to lay bare the fact that many of the problems, which will appear as war and post-war problems, are actually problems which have been with us long before the war started, but which now appear having borrowed from the war its intensity, its emotional urgency and

some of its claims upon our devotion. I have in mind such matters as economic reform, equality of opportunity, and minority rights. These three great issues are emerging with added import as post-war problems. They are matters which will clearly affect the return of men and women to civilian life. It seems to me nonetheless important that those of us who wish to think clearly and constructively on the return of men from war, who mean to draw up plans and see them put into action, should see these other matters in terms of long-term problems which had their origins long before this war and which have to be solved on their own merits.

Having now separated off from the matter under consideration much which did not truly belong to it and much which served unnecessarily to magnify and to confuse, what remains? First as to the general setting. We are coming to the task of working out the most effective way of returning one-tenth of the population to civilian ways of living, acutely conscious of the experiences of the last war and the last peace. We are aware that in all countries that return was exceedingly difficult, that it took a long time, and that in some countries large bodies of men, for all practical purposes, never did return to civilian life. They remained outside their civilian world, critical, resentful and hostile and eventually forming, in Germany, as prime example, Hitler's first recruits his private army which, as the Brown Shirt Organization, first destroyed civilian government in their own country before giving him the strength to destroy that of almost all Europe. In varying measure this was true of all countries. Dislocated, dispossessed men everywhere added to the vast unrest and discontent of the nineteen twenties and nineteen thirties.

All this forms the solemn and the serious background to our approach to this matter. We are aware that our attempts to understand our world, to meet human needs upon a basis of economics alone, have failed despite the fact that our means of production have increased immeasurably, despite the fact that world-wide freedom from war is now a matter only of better planning. We stand tragically before the fact that at no period have conflict, insecurity and social collapse been more widespread.

Offsetting this dark picture are the efforts which have been made to work out a sounder basis for our attempts to deal with our society. Under the pressure of these great necessities there has been an immense growth in the sciences concerned with the study of human behaviour. The human factor in industry, psychological warfare, industrial counselling, personnel selection, the psychological preparation of men for war these are words of growing potency and weight. They were heard rarely, if at all, before the first world war. They, and the thinking of which they are an expression, are likely to be of the greatest moment in solving the problems of a world-wide return from war.

What new light does this approach throw upon our problems? It reveals a fact of the first importance, namely, that the economic aspect of a job is not necessarily the aspect essential to the satisfaction of the man. Admittedly the recompense must reach a level compatible with decent living but beyond this are certain other and often greater values. The job must afford the man a measure of prestige and standing with his fellows. It must afford him a degree of satisfaction, a means for obtaining a sense of accomplishment. Recently we have seen a number of men who have been discharged from the army and who have returned to their old companies. In the meantime their positions had been filled by others. The returned man has been put back on his original salary and the administration has felt, apparently quite sincerely, that the right and the just thing had been done. But with the salary did not go the actual responsibility, the opportunity to develop the position, the status which the man had formerly enjoyed. Almost universally in such cases there has been a mounting sense of frustration and of grievance which is reasonable if we approach the matter with an understanding of human nature, but which would appear irrational if we were to attempt to see the living person in terms of the old narrow and unrealistic concept of the economic man.

But what would have seemed more unreasonable three decades ago than that a man should be discontented and frustrated when he was being paid his old salary without any of his former responsibility to carry and with much less work to do? The extent to which we are conscious of the fact that the position under such circumstances is a potential source of frustration for the man and trouble for the organization is the measure of our progress in our attempts to organize our times on a sounder basis.

This, then, is the setting in which we face the immediate future, the dark memories of the past three decades, the building up of new ways of dealing with our society based upon knowledge of human behaviour. What facts have we concerning the points at which return from war may be held up and against which strains and tensions may spring to dangerous levels?

Groups have been set up under many auspices to study these matters. From these studies the outlines of the major danger zones are beginning to appear. Considerable stress has been laid upon the fact that the man who went to war has come through a process of psychological re-education in learning to become a soldier, that his attitudes and his system of values have been changed to a degree which may render it difficult for him to adjust to civilian life. Actual investigation has shown, however, that this need not necessarily be so. From interviews with representatives of some thirty industries it was found that, at least in the case of older men, transition to civilian occupation was made comparatively easily. It was found that some of the younger men, particularly those who had overseas experience, remained restless and found a lack of stimulation in civilian life for a period which often extended over several months. If supervisors were prepared for this and were willing to deal with the situation with sufficient elasticity, the men eventually made good final adjustments.

It will be realized at once that our investigations have been concerned with men returning in small numbers and during a period of full employment. The numbers of returned men in any industry, relative to the number of men who have never left civilian life, is at present so small that the returned men tend to take on the attitudes and viewpoints of the civilian group fairly rapidly. Their numbers are not yet so large as to render them group conscious.

When considerable numbers are discharged, however, there will be a growing tendency for the returned man to become group conscious, and, in consequence, the speed with which they will shed the attitudes which they have acquired in the army will decrease. At this point we may say that all measures which serve to perpetuate a distinction between the returned man and the civilian will serve to impede the former's re-integration into civilian life. For this reason it is undesirable that, for instance, educational and occupational training facilities for returned men should be organized separately from those for civilians. It is important that, as far as possible, medical facilities which already exist and are in use for civilians should be utilized for returned men rather than that special separate provision should be made. For this reason, also, it is important that all benefits and special privileges which are to be accorded to the returned man should be rendered available as soon as possible after discharge, and should not be carried forward beyond the early transition period save, of course, in the

case of actual lasting handicap or disability. This early provision of benefits and privileges has a two-fold importance. The first has already been noted, namely, that to render them available, let us say six months or a year after discharge, is simply to provide a constant stimulation to the man to consider himself, not a civilian, but someone separate from the civilian world. The second value is that to delay according these benefits and privileges will serve only to enhance the doubts which already exist in the minds of many service men as to whether the promises which have been made. both by those in power and those who aspire to being in power, will actually be fulfilled.

Jobs, housing, the family — these three continually emerge as the primary concerns of the man who has returned from war. Other issues may have the larger ultimate consequences, or may assume the greater stature in the procession of human history, but these three are the very stuff on which the man's life is built. If his needs in respect to them are met, we may have reasonable confidence that the transition from soldier to civilian will pass through its various stages without hitch. If they are not met we may be equally sure that the returned man and his group will stand apart from the civilian world, dissatisfied, discontented and open to the manipulation of irreconciliable elements in our society.

What do we know of the attitudes of returning men towards these three? First as to jobs. There appears to be much less doubt on the part of the soldier of his capacity to handle a job than has been stated by some. This is particularly true of the man who volunteered for overseas service and who has built up a record as a competent soldier. He has as much confidence that he can deal with his contemporary civilian world as he had that he could deal with war. To a lesser extent this is true of the man who has not served outside this country. Among this group there

is a proportion who had difficulty in maintaining themselves in employment during the pre-war years. There is a tendency among them to look for greater job security in post-war employment. They want civil service jobs where they have maximum security, even though they may have to sacrifice some gain.

While many men will want to take advantage of post-war training schemes, a considerable number feel that they have not lost skill in the armed forces but, on the contrary, have acquired technical training which they might have found difficult to gain otherwise, and, for this reason, will have the more to offer on the labour market.

The provocative question as to what to do with the office-boy who has become a colonel is more provocative than actual. Wide awake personnel managers will undoubtedly agree that the office-boy who became a colonel was most certainly poorly placed as an office-boy.

One matter which is already standing out as a point of possible contention is the question of seniority rights. Is the man who left his employment to serve in the armed forces going to lose his seniority relative to the man who remained in civilian employment? This is clearly an issue which requires the earliest possible decision.

Above all problems stands the question of the availability of jobs. We have twice within a generation seen that within a period of war it has been possible to ensure full employment. If we fail to provide it when the men return we will most certainly find that we have opened the doors to those who want radically to change our society. If jobs are not available competition is at once set up between the returned man and the civilian, competition centering around some of the most elemental issues of life.

The question of adequate housing takes second place only to that of jobs. Those men who have already returned and have had to struggle with the present housing shortage have expressed in interviews the greatest resentment. At this point let me again draw the clearest possible distinction between the man who has never left civilian life and the returned man with respect to shortage of houses and shortage of jobs. The returned man has been away. The civilian world to which he has returned is not yet his again. When the civilian encounters these difficulties he becomes irked and resentful of them and may eventually attempt to do something about his difficulties. For the returned man it is the other fellow's world that is letting him down, that is cheating him out of things that he feels he underwent danger of death to protect and save. The returned man's resentment is apt to flow, not against things, but against people. Moreover, because he has been greatly frustrated by the separation from his home and by his army life, the potential hostility awaiting release is far greater in his case than in that of the man who never left civilian life.

There has been talk of holding up housing schemes until the men have actually returned as a means of supplying jobs. One-tenth of the population is to be poured back into housing that has proved inadequate for the present civilian population. Pursuit of this policy can be calculated to produce with the profoundest certainty just those consequences which we are working with the greatest urgency and determination to avoid.

In considering the various points at which return to civilian life may encounter difficulty and dangerous delay, I have left the matter of re-entering the life of the family to the last. There may be, there will be, for a number, adjustments to be made, puzzling and painful. Some will never again become part of the family which they left. But, even if these difficulties should be far more numerous than we anticipate, they will, nonetheless, remain individual. From them arises no large issue from which might take growth that group

consciousness and feeling of separation from the civilian world which it is imperative to prevent. From these individuals' difficulties the most opportunistic and power-hungry politician can snatch no catch phrase to raise him into limelight.

Some of the difficulties are figments of our own imagination. We have been told that men who have been taught to kill and to destroy will be lively customers in any family circle. We forget the fact that this experience has been limited to a very small part of the lives of our men. By far the greater part of their lives, and all the formative years, have been spent in living and working together in family groups. Moreover, in no place more than in the armed forces are the values of co-operation, of self-sacrifice for others, of interdependence set so highly.

It is to be anticipated that the matter of the wife who has sought and enjoyed employment outside the home during her husband's period of service will present a problem. While this may be brought more vividly into view, by the way, it is the outcome of a trend which has been apparent and growing since the turn of the century. It is one of the reasons for the growth of nursery schools and kindergartens, it is tied up, in a way which renders it very hard to distinguish cause and effect, with the development of labor-saving devices in the home, with cafeteria meals, with the progressive conversion of heavy manual jobs in industry into light mechanized operations. It expresses itself in the steady progress of women over the last half century to the attainment of full and equal citizenship.

Because of this, though there may be individual difficulties and clashes, it is most unlikely that the matter will become one of major consequence. Movement in the direction of greater participation by women in life and work outside the home is massive and is likely to assume dominance over any countertrends for a considerable time to come.

That the man returning to his family will be different is certain. That these differences will be so great and so lasting as to render re-integration arduous or impossible is most unlikely. He developed new attitudes and new ways in order to become a good soldier. He can even more adequately develop or return to the attitudes necessary to become a good civilian. We can take steps to further this progress. We can see to it that measures are provided which can prepare him for the resumption of civilian attitudes.

Measures have already been taken for some time to ensure that the men and women in the armed forces are kept as closely in touch as possible with their families and also with the changing Canadian scene. We are all aware of the continual drive to see to it that letters are written, that news from home gets through. Some of us are aware of the efforts to inform the men of changes in Canadian life through lectures, discussions and radio addresses. There is a great need for an extension and intensification of this process during the final weeks and months before the man is discharged. During this period the changes in attitude which were produced in altering him from a civilian to a soldier should be presented vividly to him so that he may be able to realize that he now actually does possess ways of looking at things which he did not have when he was still a civilian and which may not be helpful when he returns to his old life. The different values set upon initiative and individualism in the army and in civilian life, and the reasonableness of both sets of values in their proper places require differentiation. Together with this must go the passing over of as much factual information as possible concerning employment, training facilities, housing, farm grants and the like.

As most of you are aware, a great deal of information concerning the personality, the capabilities, and the behaviour trends of the individual soldier have been assembled from the time of his entry into the armed forces. Proper use of this material as a basis of vocational advice to him would be invaluable. This material was assembled within the armed forces for the use of the armed forces but it could be, and should be, utilized by those members of the personnel division of the armed forces, who have had industrial experience, as a means of advising men about to return to civilian life as to the occupations in which they might expect to be most successful.

Finally there is the matter of the proper preparation of the community for the return of their members from service. If each family can be put in possession, in a simple straight-forward way, of the fundamental facts which I have already outlined, it would serve to put an end to much of the confusion which is making the problem of return needlessly difficult. A similar statement for those community organizations who will perform a useful function in assisting the return, such as the service clubs, churches and the social agencies, and for those in supervisory and managerial positions in industry, is of the greatest importance.

That the job of guiding and safe-guarding the processes of return to civilian life is large and that we are attempting to deal with it by new methods need in no way deter us. The knowledge and the tools are there. What we have to fear is inertia and a lack of clear-sightedness on our part. On the part of some few others we have to fear the dragging in of issues which do not pro-

perly belong, in the hope that in the pressure and the urgency of the return, these other matters may also be carried along. We have also to fear the efforts of those who seek to confuse and disturb the processes of return with the purpose of creating so much discord that a public demand for radical measures and changes may be created.

Against all these we may protect ourselves, civilians and returned men alike, if we fix our most determined energies upon the mastery of one central objective, namely, that the returned men should once more become as rapidly and as completely as possible reasonably satisfied civilians among civilians. If we lose sight of this objective or if we fail to obtain it and the returned man and his fellows stand over against their civilian world - critical, disillusioned and hostile, we shall have created a situation loaded as it has been after every war with the potentialities of disaster. At the end of this war these potentialities have risen to a level never reached before. Our whole social organization - changing, slipping, breaking down in some areas, evolving into totally new forms in others as it passes rapidly and irrevocably from its nineteenth century form towards that future design, the outlines of which we can barely discern, it is unstable and explosive to a degree of which we have no previous record.

Do not let us be deterred from our determination to deal effectively with this matter. The road is reasonably well defined and reasonably easy to travel, if we have the will to take it.

Children in Hospital

LINDA ROBERTSON

Many students in our schools of nursing are doubtless quite familiar with the handling of children. However, there are many others who have had only the sketchiest of contacts with well youngsters and none at all with them when they are ill. In order to assist nurses in carrying out the necessary care of these children and to promote good fellowship and understanding certain fundamental psychological methods should be incorporated in the student's learning.

The basic factor which determines, to a considerable extent, the child's feeling of happiness or unhappiness is his sense of security, his feeling of belonging. When he is admitted to hospital, he loses this assurance and his reaction may be demonstrated in one of a variety of patterns. The timid child becomes introverted; the bold child may kick and scream; the "babied" child will weep incessantly. These manifestations all demonstrate fear - fear of the unknown, of the strange people and surroundings. As quickly as possible efforts should be made to restore his sense of security and to establish a regular routine.

If he is at first unmanageable, wait for him to become quiet, then tell him who some of the children are near him; explain what he must ask for if he wishes to go to the bathroom. Explain all procedures as they occur. It is not the pain he dreads half as much as the fear of not knowing what is going to happen to him. When a treatment is ordered which necessitates taking the child to another part of the hospital, make a game out of the trip. This helps to place the emphasis on something other than the dreaded treatment.

The child who frets and fusses over a prolonged period of confinement will respond happily to some suggestion of make-believe. His bed may be the landing-strip where airplanes arrive from far-away places. The wheel-chair becomes the chariot of his "Royal Highness". It need only take a few minutes each day to enlarge on this idea and make him completely reconciled by permitting him to "hold court".

When she is assigned to the children's ward, the nurse should familiarize herself with the spontaneous activities and inquiries of children at different ages. In particular, she needs to be aware of the limitations of vocabulary and adjust her conversation to the level of each patient. The health teaching which the nurse does must be based upon facts which the child understands, so presented that they appeal to him now. Most children love the sound of words that rhyme and, when the jingle is made to apply especially to him, the child will be kept happy for hours repeating some apparently senseless combination of words which nevertheless contain the germ of the idea in health teaching the nurse was trying to instil. How much more likely she is to reach her goal if the nurse manufactures some such rhyme as:

Potatoes have eyes,
But they cannot see
That they're on my spoon
Going inside of me.
instead of saying, "If you want to grow

instead of saying, "If you want to grow up to be a big man, you must eat your potatoes".

Many children have a special doll or other pet which they have been in the habit of taking to bed with them. When sickness strikes suddenly, the child may have to be whisked away to hospital and the beloved teddy bear is left behind. When she should be going to sleep, not only is the little girl all alone in a strange bed but she is lost without the teddy who always slept beside her at home. In the dark, it is easy to substitute a stuffed sock which allays the fears as the little fingers close over it. Habits, such as this, which do not interfere with the child's sleep or health should be fostered, not broken.

Children make excellent patients. It is the exception when their complaints are not justifiable. What special preparation does the nurse require to enable her to cope with any problems which may arise? Tact, intelligence, patience and good humour are essential requisites. Added to these, the nurse must try to see things from the child's point of view. Her attitude must be friendly and

sympathetic, yet firm enough that she remains in control of the situation. She must learn to speak gently and firmly, never sharply, to the children. She must make up her own mind what it is she wants in the way of co-operation. Children are quick to sense confusion and ineptness and, because they are great show-offs, will attempt to take advantage of her. On the other hand, children are indefatigable and perpetual imitators and they will respond if only to gain approval, if the nurse knows what she wants.

To sum up, the nurse will be successful in the children's department if she:

1. Establishes their sense of security when admitted to the hospital.

2. Is always truthful and remembers the need for explanation.

3. Tries to see the situation from the child's point of view.

4. Is consistent in her dealings with them.

5. Is calm and unperturbed no matter how much confusion there may be around her.

"Miss, It's a Boy"

LILIAN MACKINNON

Lying awake in my room in Camp Lewis hospital the moonlight night of July 1, 1944, with two blankets tucked cosily around my shoulders, I considered myself very, very lucky indeed. Outside, the lake, a scant twenty yards away, slapped softly at its shore and a whip-poor-will in a tree close by called thrillingly throughout the night. Less than eighty miles to the south, Montreal was sweating out its first and fiercest heat-wave of the summer. People were waiting for hours to catch a train to the Laurentians and here was I in the very heart of them, and being paid to stay!

My satisfaction extended into and throughout the following day when, the morning mist drifting from lake and shore, the moonlit impressions of great scenic beauty I had had during the night were more than fully confirmed by the brilliant northern sunlight. The camp site was truly lovely. The main building, which overlooked the lake, was an old, picturesque grey stone dwelling known as the Chateau, and in it were the dining-rooms, kitchen, offices, etc. It also housed the camp personnel with the exception of the director who lived in a cottage near the hospital, both buildings perched high on the side of a steep hill above

the Chateau, and reached by a long flight of shallow stairs.

The cabins and tents for the boys were on sheltered Presqu'ile separated from the Chateau by a narrow bay and almost entirely screened by the thick leafy green of the trees. On the shore a beautiful high rock shelved into the lake, a gorgeous spot for bathing, and nearby were the wharf and divingboard. Clustering red-painted boats made a spot of colour against the green backdrop.

Had I anticipated the responsibility devolving upon a camp nurse when the camp in question cares for some two hundred and fifty boys as Camp Lewis did, I might have gazed at the sparkling lake and surrounding mountains with a degree less equanimity that perfect Sunday morning. For on Monday the boys, carrying their city pallor and knapsacks and shouting their marching songs, arrived in Camp Lewis. I looked no longer with tranquil spirit at the lake, and if sometimes at night I lifted harassed eyes for a moment to the Great Dipper, I never did hear the whippoor-will again in the tree below the hospital for, with the coming of the boys, he fled to quieter haunts.

Thereafter life in Camp Lewis cen-



A perfect setting at Ste. Agathe des Monts

tered in and revolved around the boys. All day long the campus and Chateau echoed to their voices. All day long, and all too frequently at night, they arrived singly or with an escort, depending on the box-office attraction of the case, up those terrible stairs to thunder, as if their very lives were at stake, on the hospital door. In former years Camp Lewis boasted a doctor's services but times being as they are this summer a nurse had to substitute. This was a little hard on the camp since its isolation made the presence of a doctor almost a necessity.

As the glorious summer days sped by, I found myself like St. Paul trying to be all things to all men, or at least to all boys. I discussed social adjustments, gave shelter and pep talks to the homesick and much free advice on personal hygiene. The feet I cleaned and bound up will do me quite nicely the remainder of my life. Though most of the injuries the boys received were of a minor nature, here and there a more serious cut, necessitating sutures, cropped up. Two of those I sent to Ste. Agathe but in several cases I myself put in a few horse hair sutures and later had the satisfaction of seeing the wounds heal.

Probably it was luck but I think it

was sulphathiazole ointment that kept injuries clean for only in one instance did a boy have to go to Montreal for treatment for infection. Poison ivy cleared up beautifully after a few treatments with potassium permanganate solution, while boils were grimly incised and dressed with sulphathiazole; I also used it for bad cases of sunburn. When to give anti-tetanus serum proved a major worry.

I sent one case of measles and another of pink eye to Montreal and was lucky enough to have no other cases develop. To Montreal also went an acute abdomen, an infection of the middle ear and a second degree burn; but all these patients were seen first by a doctor in Ste. Agathe.

Now I must not allow you to think I did all this work by myself for that would be giving you an entirely wrong impression. Not at all! Two orderlies, thirteen and nine years respectively, known as Mike and Junior were my very perfect assistants. They washed so many feet and helped with so many dressings, without audible protest at least, that sometimes I weakly looked aside when I saw them bandaging soiled ones. They kept the hospital clean and fed the sick, and when a patient, feet

racing or lagging up the long flight of stairs as the case might be, announced his arrival at the hospital with loud cries, a conversation something like the following would ensue:

Myself (Having sought the comparative sanctuary of my room and trying to concentrate on something else): "See

who it is, Mike".

Mike (His voice raised hoarsely above the clamour in the surgery): "Miss, it's a boy."

Myself: "Well, go on and fix him up."

Mike (Outside my door, his voice still hoarsely raised above a perfect chorus of shrill cries): "Miss, it's his foot."

Myself (Still intent on my personal

work): "Go ahead, Mike."

Mike (Accusingly, now inside my room and trying vainly to stem the tide of pushing boys): "Miss, it's a Nail!"

Myself (Resignedly, mentally tossing my work out the window because nails, and above all rusty ones, were my special dish): "O.K. Now you boys scram out of here."

Poor little orderlies! At night they climbed a ladder to sleep with the scurrying chippies under the hospital eaves, and day in a burst of confidence told me of their ambitions to become great specialists; and I can only hope that Canada in the not too distant future, her war ended, will place within the grasp of all her poor, ambitious, clever children the means of obtaining a college education.

To-night it must be very lonely in

Camp Lewis. The ghost on Ghost Rock, always a cold, unfriendly spirit, must brood gloatingly over the dark and silent Chateau, and the forbidden and forbidding Rock of Gibraltar must appear as withdrawn and remote as the glittering reflection of the nothern stars in the cold and silent lake, while the waters of the Suez must flow with an unnatural tranquillity over their brown sands. Perhaps the whip-poor-will, if he sings this early in the Spring, has come back to the tree below the hospital but his clear notes can only emphasize the eerie silence of the campus.

On the Great Rock of Leukamis the new green leaves will be budding. This is where Louis, the descendant of Mohawk Chieftains, told his beguiling tales to an awed and silent audience, and where to prove their worthiness of admission into the Honour Tribe, the young braves, to the accompaniment of shrill cries and the beating of tom-toms, were tortured at the stake before the huge camp-fires and later, their faces to the lake as the light died upon it, the members of the tribe chanted their invocations to the Great Turtle. Here, over the dead ashes of many camp-fires, the Great Spirit must wonder if those eager young warriors will one day be called upon, as so many of his former braves were called upon; to prove that manhood in flaming skies or in dark and lonely oceans. Like the campus and the Chateau and the hospital He, too, must wait for the coming of summer and the return of the boys.

Bromism

EDITH M. PULLAN

In the study of materia medica a portion of the study of each drug is devoted to toxicology. The alert and observant nurse with a good foundation of fundamental knowledge can prevent the toxic symptoms occurring in a patient while in hospital, through proper and prompt application of theory and practice. The patient is thus safeguarded because he is under constant observation. The average out-patient has a limited or no background of knowledge which would enable him to realize the danger of taking medications beyond certain limits. This pertains especially to some of the ingredients which are contained in patent medicines.

There are certain drugs which are used extensively in patent medicines that are proving to be the cause frequently of toxic conditions. The drugs to which I refer are the bromide salts. These drugs are used in many so-called nerve tonics and headache remedies. Bromides are available to the public by just requesting them from a pharmacist. Moreover, a prescription containing these drugs can be refilled unless, of course, the physician especially states otherwise in the preliminary prescription.

Let us review the action of the bromides. They affect the central nervous system in such a way as to act as a depressant. They act on the entire nervous system, the brain, the spinal cord and the nerves. They relieve pain slightly and produce sleep, especially in nervous patients. The mental activities become rather sluggish. There is a diminution of the response of the muscles to stimulation, a lessening of nervous and emotional excitability and a decrease in reflex action. Because the bromide molecules are too large to pass through the tissue in the glomeruli of the kidney, they tend to accumulate in the body tissues thus producing a variety of effects. One effect of this accumulation is a skin rash caused when an attempt is made by the body to eliminate the drug through the skin. The rash may become very pronounced and develop into ulcers. The second effect may be a mental condition that is characterized by certain changes in behaviour and mental mechanisms. The signs and symptoms displayed are usually characteristic when the toxicity affects the patient in this particular manner. He becomes extremely confused, losing the ability to organize his thoughts.

Familiar objects resemble nothing that is commonplace. He fails to recognize the day or month; he has no idea of his surroundings; they do not convey to his mind the memory of previous experiences. His friends are strangers to him. Furthermore, the thoughts that are in his mind are often vividly interpreted by false sensory impressions or hallucinations. Impressions of a visual nature are most common. These usually take the form of very fantastic, frightening monsters or wriggling objects. These are very often described in detail by the patient. They appear to him to be very real and markedly influence his behaviour. Other sensory perceptions which may be manifest are false sensations of taste, such as a feeling that the food is poisoned, or false auditory sensations are heard. Combined with these abnormalities of mental activity and behaviour is the failure to heed visceral stimulation, resulting in faulty habits and incontinence. Also there is a marked tendency to disrobe.

The patient's need for medical treatment and nursing care is very great. The curative treatment is specific and extremely effective when instituted. Sodium chloride, grains fifteen to twenty, is given by mouth, three times a day. If this form is not tolerated, it can be given intravenously. Fluid intake is increased by intravenous infusion of 1000 to 2000 cc. of 5 per cent glucose in saline daily. Vitamin B is given intravenously also.

The nursing care is extremely important. The environment must be protective in order to prevent the patient from becoming harmed due to his activities. Daily baths stimulate the elimination of the toxic substances through the skin. The water used for these baths should be as warm as possible to activate the sweat glands. This immersion removes any of the irritating bromides from the skin surface, thus preventing ulceration. Care must be taken to remove all excreta from the skin because these patients neglect personal habits. Nourish-

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PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses
Association

Personnel Policies and Practices in Public Health Nursing

DOROTHY DEMING

Public health work is a partnerconcerned with promoting good public relations. No matter how skilled your staff, or complete your equipment, or beautiful your building, the health of the public will not be greatly advanced if your relations to the people in your community are not happy. The impression which the public receives of your work stems mainly from personal contacts — day in and day out. It is trite but true to say that even the tone of voice of the clerk who answers the telephone influences the public's reaction to your service. How much more important is it then that the members of a staff who meet clients at home, on the street, and in clinics be equipped with every advantage and skill in making and keeping friends. Underlying the productive capacity of workers to win the public's friendship are smooth-working relationships within the staff itself - what we call fair personnel policies and sound administrative practice.

Let us examine the working relationship between the health officer and the nursing staff. What factors promote good service to the public?

The public health nurse expects three perfectly definite things from the health officer.

The first is information. She expects,

if she is new to the position, to be told about the health department's program, the plan of work, the special problems in the community as the health officer sees them. As she becomes familiar with these, she expects to be kept informed of new developments, of changes in policy or schedules. Many a health officer has been known to initiate new services, discontinue routines or change policies without discussing them with the nurses - indeed without even notifying them. It is pretty disconcerting when this happens. Not only is the day's schedule upset, but sometimes the staff nurse is left "out on a limb" quite unsupported by her department. May I give a simple example?

A health officer discontinued Schick testing the children entering school in the preschool clinic, having agreed with the school physician that the latter would take over the job. The field nurse was not notified. She had in the meanwhile laboured hard to persuade Mrs. Jones to take her two preschool children to the clinic for the Schick test. At last Mrs. Jones appeared, her brood in tow, only to be told that the test had been discontinued. How much faith will Mrs. Jones have in her public health nurse in the future? How kindly does the nurse feel toward her health officer?

The public health nurse wants infor-

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mation of a formal kind also. Are you planning to use a new drug, new technique or new approach to a problem? The more the public health nurse knows about it the better assistance she can give you. Keep her up to date, please! Urge her to attend professional meetings and subscribe to professional journals. Share your new books with her. She wants to feel that you welcome her questions. Make it easy for her to consult you. If several nurses are employed, they will expect some formal in-service training, especially before the introduction of a new service.

The second attribute the nurse expects to find in the health officer is understanding. When only three people show up at clinic when thirty are expected, when the newspaper reporter misquotes the figures of the annual budget, when Mr. John Doe blows up in the office about the "neglect" of his condition-please get the facts before you take a stand implicating the nurse. The nurse protects you from many a hard knock and she expects you to understand the conditions under which she is working. She assumes you are on her side. In a true partnership not only are triumphs and failures shared but policies are adhered to until mutually abandoned. A public health nurse once said to me, "When Dr. Blank gives us his orders, they are not orders at all, but plans for a joint adventure."

Lastly, the public health nurse looks to the health officer for inspiration, and I really mean inspiration. Is her work good? Why not tell her so. Have you just received figures showing a lowered death rate from tuberculosis, or lower infant mortality? Share the report with the nurse before she reads it in the newspaper. Has that appropriation come through for a new x-ray machine? Interrupt staff conference and tell the nurses! Most important, give credit where credit is due. Elementary? "Very elementary, Dr. Watson!"

To consider the reverse side of this partnership. What does the health of-

ficer expect of the public health nurse?

The first is preparation. He expects the nurse to have had sufficient special training in public health to understand the aims of his program and the methods of attaining them, so that he can entrust the nursing service to her. If only one nurse is serving on his staff, he expects her to come to him when necessary, but to be quite capable of planning her work and proceeding without his constant oversight. He wants to have the kind of confidence in her that he would have in a business partner, so it is up to you-in your turn, Miss Public Health Nurse, to share your successes and failures relating to the service with him and discuss new plans before adoption.

Secondly, we may as well face it the health officer seeks a good-looking nurse! Perhaps no more hopefully than the public health nurse looks for a handsome health officer. We might compromise on personal neatness, good health and mental alertness. Throw in good judgment, dignity and tact, and you have an acceptable worker under any title. Naturally, you want a contented worker. Pleasant, convenient living quarters, a good salary with regular increases, promotion for satisfactory work, and generous vacations and sick leaves all tend to make happy as well as healthy workers. You should, of course, require a satisfactory health record when a nurse enters a position. If you want to maintain energetic, interested and alert nurses may I suggest you set a good example yourself, doctor? Do you-for instance-take preventive sick leave, a long week-end or two or three consecutive days off, when you have been putting in a lot of overtime? Do you come back on a part-time schedule for a week or two after a bout with serious illness? Do you stay home when you are in the coryza stage of the common cold? If you do these things, the nurses will, too. After all, a teacher with the sniffles is not a very convincing example to others of the grave danger of spreading disease through coughs and sneezes. One of the reasons you have a right to expect a wholesome looking nurse is because the public judges your product by her appearance. Sickly, untidy, weary nurses cannot sell health, whereas an attractive, workmanlike appearance inspires confidence. Miss Marion Howell has expressed this well: "In one day a public health nurse, attractively uniformed, well poised, cheerful and enthusiastic, making her way from home to home, from school to school, from one part of a large factory to another, or meeting many people in clinic, may do much to make or mar the standing of nursing in the community."*

This is the day of uniforms, and their convenience, general becomingness and good style are appealing to all nurses, besides providing the public with a means of recognition. If your nurse wants to wear a uniform, encourage her to do so.

The third quality a health officer looks for in a public health nurse is maturity of judgment and action. I really think a health officer expects more self-reliance and common sense from a public health nurse than from anyone else in the world-not excepting his wife. When everything goes wrong, half the staff are ill, flu is rampant, the clinic overflowing with patients and the doctor's car breaks down six miles from the office — the public health nurse must carry on. You expect her to conduct herself on all occasions with restraint, affability and intelligence. You expect her to improvise a sphygmomanometer sleeve from an old tire tube or a tire tube from an enema bag! Nothing is beyond her. And that is as it should be. Reliability is a fundamental characteristic and indispensable to the program you are directing.

What if the business partnership does not live up to these high ideals? The health officer may find the nurse flighty, the nurse may look in vain for explanations of policies from the health officer.

*Public Heal h Nursing, May 1941, p. 298.

That is the point at which the nursing supervisor or consultant has her greatest usefulness. She steps in as the "great facilitator." To her should go all problems relating to individual difficulties. I well remember the occasion some years ago when a health officer with a staff of ten nurses asked why he should spend city money on a supervisor. He had always supervised the nurses himself. Our national staff gathered a bushel-basketful of reasons. I give you a condensed version of them.

Primarily, the supervisor adjusts the details of the nurses' work to the needs of the community in accordance with the large plan adopted by the health officer — thereby saving time and overlapping of effort, and stretching the service to reach more people.

The supervisor interprets the capacity and reactions of the staff to the administrator and his administrative policies to the staff. She is an impartial spokesman for the members of the partnership. This interpretation is not something that is done at ten o'clock Monday morning. It is a continuing, finely adjusted process requiring close observation of the daily work of the staff and a clear understanding of the purpose back of the health officer's plans.

The supervisor serves as a teacher of (1) the new nurse learning the work; (2) the nurse not so completely prepared as we could wish; (3) the nurse facing new or difficult situations; (4) the whole staff when the number warrants in-service training programs; (5) the students assigned for field practice.

The supervisor develops community relationships and resources, is sensitive to social trends and legislation as they affect the nursing work, and finally, the supervisor guides each member of the staff toward the attainment of her fullest capacities.

Today, every health officer has a right to expect good work from wellprepared nurses under competent supervision.

I have tried to offer some very simple

suggestions for strengthening personnel policies in health agencies and to point out places at which the machinery may squeak a bit, thus threatening the good impression we make upon the public. Whether you need to use the oil can or want to—only you who are in the partnership know. I recommend listening rather frequently for sounds of faulty gears.

Metropolitan Health Committee, Vancouver

The following nurses were recently appointed to the staff of the Metropolitan Health Committee, Vancouver:

Margaret Carswell (University of Alta. Hospital and University of Toronto); Corinne Eriksson (St. Eugene's Hospital and University of B. C.); Dorothy McKerracher, B.A. (Royal Victoria Hospital and University of Western Ont.); Queenie Donaldson (Ottawa Civic Hospital and University of Toronto); Margaret Cammaert, B.A.Sc. (University of Alta. Hospital); Jennie Hocking (Royal Jubilee Hospital and University of B.C.). Miss Hocking has returned to the Metropolitan Health staff following a year's absence. Mrs. Margaret Allan, B.A.Sc. (Vancouver General Hospital and University of B.C.); Miriam Coone (Royal Columbian Hospital and University of B.C.)

Mrs. Jeanne (Gall) Worrall. B.A.Sc. (Vancouver General Hospital and University of B.C.) has been appointed on a half-time basis as a public health nurse. Mrs. Shelagh

(Williams) Harris (University of Toronto); Mrs. Sadie Duggan, B.Sc. (University of Alta.); Dorothy Ehnes (University of Toronto); Betty Chinn (Royal Alexandra Hospital and University of Alta.); Marion Macdonell, B.A.Sc. (Vancouver General Hospital and University of B.C.) Miss Chinn and Miss Macdonell have been granted leave of absence to join the R.C.A. M.C.

Dorothea Shields (Winnipeg General Hospital and University of B.C.) has been awarded a scholarship by the W. K. Kellogg Foundation for a three-month period of study in the State of Michigan. Phyllis Reeve (Hospital for Sick Children, Toronto, and University of B.C.) and Norah Armstrong (Vancouver General Hospital and University of B.C.) have returned to the staff following completion of the supervision and administration in public health nursing course at the McGill School for Graduate Nurses. Mrs. R. (Granger) Greenwood (Vancouver General Hospital and University of B.C.) recently resigned.

Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers and resignations from the Victorian Order of Nurses for Canada:

Marion Slater (University of Toronto School of Nursing) has been appointed to the Toronto staff.

Marion Scholfield has been transferred from the Toronto staff to take charge of the Cobalt Branch. Lucille Beaudet has been transferred from the Moncton staff to take charge of the branch in Digby temporarily.

Gladys Boreman has been transferred from the Galt staff to take charge of the Guelph Branch. Edna Dysart has been transferred from the Digby to the Moncton Branch.

Jean Williams has resigned from the Cobalt Branch and Olga Friesen from the Kitchener Branch and have been appointed to UNRRA. Annette Martin has resigned from the Guelph Branch and Pauline Roger from the Sherbrooke staff to be married. Blanche Bishop has resigned from the Toronto staff to accept a position in industry.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A

Tuberculosis Affiliation Course

FERNE TROUT, B.A., B.A.Sc.

DETAILS OF ORGANIZATION:

For some years past, most of the schools of nursing in British Columbia have had a percentage of their student body receive some theory and training in tuberculosis nursing. Until 1943 this experience was provided mainly by the in-patient treatment centres of the Division of Tuberculosis Control, which are located at Vancouver, Tranquille and Victoria. Stress was put on bedside nursing techniques. With the spotlight now focusing on more efficient casefinding methods, more adequate clinical facilities and an expanding public health program, tuberculosis nursing has broadened in outlook and scope. As a result of these changing ideas, in the Fall of 1943, it was decided, after members of the Division met with representatives of the Registered Nurses Association of British Columbia, that the affiliation course should be centralized, should include experience in all phases of the work and accommodate as many as possible of the student nurses in British Columbia. The cost of the course was to be defrayed by the Provincial Government. In July of 1944 a qualified instructress was placed in charge of the course which was organized at the Vancouver or Central Unit of the Division. Twenty-eight affiliating students changing every five weeks enables the students from five of the province's seven training schools to obtain a concentrated course of theory and practice in tuberculosis nursing. Of the two schools not participating, one has organized a course as much along the same lines as possible, and the other is unable to utilize the facilities at present, because of the lack of living accommodation for the students.

THE PHYSICAL SET-UP:

The Vancouver Unit of the Division of Tuberculosis Control is located at 2647 Willow St. It includes an in-patient treatment centre of 160 beds and the main Stationary Clinic for out-patients. The treatment centre accommodates both medical and surgical cases and most of the chest surgery for the Division is done in this Unit. Also, medical and diagnostic problem cases are admitted to this Unit where specialist services are available. The Stationary Clinic is divided into two distinct parts. The Survey Clinic carries out an extensive case-finding program and the Diagnostic Clinic provides complete diagnostic facilities as well as giving treatments to out-patients and supervising charged cases.

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HOW THE PLAN ()PERATES:

Before commencing affiliation at the Division of Tuberculosis Control the students have had approximately two years training at their parent school. They have had lectures in communicable diseases and learned isolation technique as it is carried out in their own hospitals. The students come in in two groups, one week apart. This necessitates repeating introductory lectures, but it also means smoother administration from staff placement point of view and gives the students some orientation and out-patient clinic experience before they proceed to the district.

The morning of arrival they are first given a lecture on tuberculosis techniques and emergency treatments. This includes a demonstration of gown technique. Before proceeding to the wards and departments the students are all given tuberculin tests and miniature x-ray films are taken. This is done routinely the first day unless the student complains of a very severe reaction to a previous tuberculin test, in which case the x-ray film only is taken.

With just five short weeks it is neces-

sary that the students be rotated quickly to ensure uniform experience for all. Each student spends two weeks on one of the medical floors and a week each with the surgical department, out-patient clinic and the Metropolitan Health Committee, which is the health agency for the city of Vancouver.

While on the medical floors they do bedside nursing and carry out all routine procedures. The regulation garb worn on duty is a short sleeved Hoover uniform. An isolation gown is worn over this when in active contact with the patient or his belongings. Each week a patient on the floor is discussed at a student conference. These discussions are informal, and the cases chosen illustrate some of the social and medical aspects which together have contributed to the individual's breakdown. A social worker and the student instructress attend and try to help the student visualize the full scope of tuberculosis nursing and the community and social aspects which are so important. In the surgical department experience is given in bedside nursing of thoracoplasty and other surgical cases. Whenever possible students are permitted to see any special treatments or operations.



Giving nursing care

The week in the out-patient clinic always directly precedes the week with the public health agency. Here the affiliating students see how our Survey Clinic operates, doing tuberculin testing and taking miniature x-ray films. In the Diagnostic Clinic they learn how histories are taken, physical examination and other differential diagnostic procedures are carried out. Film readings, bronchoscopy and lipiodol injections and other special examinations are observed and they are given an opportunity to participate in clinic activities as much as possible. They also attend medical and rehabilitation staff conferences held week-

The Metropolitan Health Committee in Vancouver carries out a generalized public health program in the community. Consequently, when the students are with the Committee they are assigned to a public health nurse and have the opportunity to observe all phases of the community health program, infant and pre-school welfare, school health services and tuberculosis being the three main services covered.

The lectures given are eighteen in number and run concurrently with the practical experience. Since the students have no night duty and work straight eight hours, they are given during onduty time. This also allows parent schools to arrange any other lectures at non-conflicting hours. Lectures are presented by six doctors, specialists within the Division, the heads of the diffe: ent departments such as clinic, social service and laboratory, and the student instructress. At the end of the five weeks a written examination is given. A reading room is available to the students where reference texts and current magazines are on hand. The main text on which our lectures are based is the "Handbook on Tuberculosis" by Dr. W. H. Hatfield, which came into print last year. This book refers more specifically to this provincial set-up and is available to the students at twenty-five cents a copy. When circumstances permit, stu-



The Vancouver Unit

dents are allowed off the wards to do assigned reading.

On completion of the course, a resume of student experience is sent to the parent school with their examination mark and a rating sheet drawn up to cover all specific phases of the course. In so far as health follow-up work is concerned, any student coming in with a negative tuberculin test is re-checked six weeks after completion of the course. This is done by the parent school with material sent from the Clinic. If any other follow-up is necessary the hospital may do it or they may refer the case to a Clinic of the Division of Tuberculosis Control.



Regular lectures are included

PROBLEMS:

This briefly outlines the course. Now, some of the problems which come to the fore when a hospital assumes the responsibility of an educational institution. First, is the integration of classroom teaching and ward practice. This difficulty is being overcome by the development of an organized in-staff educational program. Head nurses and graduates are given the opportunity through regular staff meetings of discussing problems, changes in policy or routines, and trends which are of interest to everyone. More stress is also being put on sub-staff standards, definite teaching and orientation of orderlies and ward helpers. The patient teaching program, too, is at present progressing on a more systematized uniform basis. The success of any institutional teaching program, which includes so many phases, depends on the whole-hearted support and co-operation of all individuals concerned.

A second problem at this Unit has to do with living quarters for students from out-of-town schools. There is no residence here and, at present, parent schools must make the arrangements for living accommodation. Some of the students commute some distance each day and this means not only inconvenience to the nurses but necessitates arrangements for hours compatible with travelling conditions. When the housing situation becomes less acute, living accommodation may be arranged close to the hospital for out-of-town affiliates.

Since this course has gone into effect most enthusiastic co-operation has been received from the training schools and the students. The work is both interesting and worthwhile. Problems are constantly arising and policies need many changes and modifications but on the whole a little thought and effort seems to keep things running on a fairly smooth basis. Both students and staff have responded most satisfactorily and

it is our hope that this response will have far reaching effects.

Possible Results:

Many sanatoria throughout Canada complain of inability to obtain staff mainly because of fear of contracting the disease and lack of specific knowledge concerning it. In British Columbia, we feel that these problems should be dealt with during the training period by including supervised, planned experience in tuberculosis nursing as part of the curriculum, and that such problems will then resolve themselves. Certainly, graduates who feel unqualified and who have had no incentive will not voluntarily choose an unknown field to specialize in. And yet, it is a field which stimulates nursing ability, knowledge and skill, and if presented in its proper light should attract worthwhile personnel. Consequently, we consider that this step will definitely show results and that it is an important part of our whole program.

It is also well recognized that participation by every individual in the community is essential before tuberculosis can be controlled and that a planned educational system is necessary if each individual is to be brought to the realization of his responsibility as a member of the community. The effectiveness of any educational program depends on the alertness, interest and qualifications of a well-trained staff. Nurses, regardless of what branch of nursing they pursue, are in an ideal position to teach the salient facts of prevention and control but only by affiliation can we stimulate their interest, bring about a realization of the extent of the problem, and provide them with the necessary knowledge and skills to help overcome it. Their participation in this program is part of their contribution both as citizens of their community and as members of their profession.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

An Interesting Surgical Case

DOROTHY THOMAS

Mrs. S. was not the usual type for gall bladder trouble, her weight being about 110 pounds, thirty-nine years of age, and slightly over five feet in height. For nineteen years she had had occasional attacks of dizziness and vomiting preceded by dull aching pain in the left scapular region. For the past six and a half years there was also pain in the epigastrium, at first a smothering sensation, becoming acute pain. During the last two years attacks were more frequent. Constipation was marked though no jaundice was present. There was some tenderness in the upper right quadrant of the abdomen.

Mrs. S. entered the hospital June 20, 1944, and x-ray of the gall bladder indicated cholelithiasis. She was prepared for operation and as she was very nervous was given divided doses of luminal in the afternoon, seconal grs. 11/2 at bed-time. Seconal grs. 3 was given preoperatively.

When the cholecystectomy was done under general anesthesia, a large number of small stones were found in the gall bladder. The common duct was explored and no stones found in it. Upon return to her room her pulse was quite weak and irregular for a few hours. However, she has low blood pressure and her pulse is always easily compressed. Two thousand cc. of 5 per cent

glucose in normal saline was given intravenously.

Previous experience indicated that Mrs. S. did not tolerate any derivatives of opium, so sufficient seconal in 3 grain doses was given rectally to keep her drowsy for the first three days. She was very restless and changed her position every ten or fifteen minutes.

Progress was good except that a slight jaundice was noted on the second post-operative day. Jaundice became more marked but varied from day to day, at times appearing to clear. Urine contained visible bile and stools varied from gray to brown.

She sat out of bed on the tenth postoperative day and was discharged from the hospital on the fourteenth day. The doctor was quite disturbed about the jaundice but decided to watch her for a time. During the following weeks she was greatly troubled by itchiness of the skin. Her bowels moved very freely and the stools were gray and grayishbrown in colour, the urine contained much bile.

Mrs. S. returned to the hospital September 4, 1944, very jaundiced, skin dry and very itchy, temperature 99.2 degrees. She had had a cold and was still coughing. Her urine contained much bile and a trace of sugar which persisted for one week. Hemoglobin 68 per cent,

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R.B.C. 3,620,000, W.B.C. 9,150. Her bowels moved freely, some stools were gray and others grayish-brown in color. She was allowed bathroom privileges. One ampule of vitamin K (Kavitan) was given intramuscularly, daily. Her appetite was fair and she was given a low-fat diet.

On September 9 a transfusion of 500 cc. of citrated blood was given and on September 11 her hemoglobin was 91 per cent, R.B.C. 4,350,000 and W.B. C. 9,500. Cough medicine had very little effect but Mrs. S. slept fairly well at night. Her temperature was normal with occasional slight elevation. Bleeding time was 3 minutes and coagulation time, 6 minutes 20 seconds. The doctor decided to operate on September 12.

Mrs. S. was able to secure the same three nurses she had had before, and this gave her more confidence and she was much more resigned to the second operation than to the first. Luminal was given the night before and seconal grs. 3 per rectum, one and one half hours before going to surgery.

It was a very difficult operation, taking three and one half hours. Adhesions had caused a kink in the common bile duct and it was hard to separate the duct from the portal vein. The upper end of the common duct was opened and a No. 18 catheter was inserted into the duct up through the left hepatic duct to the liver and sutured with No. 0 catgut, the other end implanted in the stomach wall for a distance of 5 cm. down to the mucous membrane. The tube will ulcerate into the lumen of the stomach. A Penrose drain was placed in the upper part of the incision. The operation was done under general anesthesia — pentothol sodium 1.0 gm. intravenously, followed by ether.

Transfusion of 500 cc. citrated blood was started immediately upon return to her room, followed by 5 per cent glucose in normal saline intravenously. Pulse was a good quality, 112 gradually dropping to 90, respirations shallow and ranging from 30-36 per min-

ute. Mucus in her throat was troublesome and considerable clear and white
frothy mucus was expectorated. There
was no nausea. She was conscious shortly after returning to her room, and
very restless, changing position about
every fifteen minutes. She was kept in
a twilight sleep by seconal given rectally for the first three days; to all appearances she was asleep but would do
what she was told to do. She was given
only hot water by mouth for three days,
and 5 per cent glucose in normal saline
intravenously.

The day following her operation transfusion of 200 cc. of citrated blood was given. Each transfusion was followed by elevation of temperature but no other ill effect. On September 14, her hemoglobin was down to 72 per cent, R.B.C. 3,930,000, W.B.C. 20,-000. There was considerable sanguinous bile drainage. She had very little distress from gas, and progress was satisfactory. No intravenous was necessary after the fourth post-operative day, as she was taking adequate fluid by mouth, although she was nauseated that day for the first time. While she was so drowsy it was necessary to catheterize her; the urine contained much bile and had an offensive odour.

There was a slight enlargement of the abdomen which could not be accounted for and during the night of September 17 her temperature rose to 102 degrees, her pulse 110, respirations 36. There was engorgement and discoloration around the incision. On the morning of the 18th, the doctor removed one suture and probed the incision. There was a medium amount of dark sanguinous discharge. This increased in amount and became bright red. In the evening a pressure pad was placed over the wound. Bleeding continued and became quite alarming although the pulse remained a fair quality and did not go above 122. On September 19, neohemoplastin 5 cc. was given and repeated in four hours, also two transfusions of 500 cc. each were given and

by midnight the hemorrhage was under control.

On September 20, her bowels began to move very freely, the stools grayish brown and brown in color. This laxity continued until October 3, when she became quite constipated and it was necessary to use enemata and laxative.

On September 22, the skin clips were removed from the upper part of the incision, the lower part having been closed with silk thread. On September 23, the temperature was normal, pulse 90, respirations 24, and Mrs. S. was at last able to take soft diet although her appetite was not good. September 27, the Penrose drain and all sutures were removed and another transfusion of 500 cc. was given. There was free bile drainage until October 1, when it suddenly stopped.

Mrs. S. felt better and was sitting up in bed and on October 3 sat with her feet out of bed. The next day she complained of distress in the epigastrium which she described as wave-like contractions in her stomach. This appeared to be aggravated by the ingestion of food and made it difficult for her to eat. She eructated much gas. By evening her temperature was up to 101 degrees, she was depressed and very exhausted.

The following morning she had an emesis which contained bile, she ached all over, perspired freely and by the evening of October 5 her temperature was 103.8 degrees, pulse 118, respirations 26. During the night the incision began to drain bile again and the temperature dropped to normal. The contractions gradually became less marked and appetite improved. Jaundice which had varied in degree, at last began to definitely clear.

On October 7, the urine contained very little bile and continued to be light

in colour. The cough was persistent, appearing to be due to post-nasal drainage, and was more marked in the early morning. October 10, Mrs. S. sat out of bed for twenty minutes. The jaundice was not clearing as fast as we had hoped, and she was becoming somewhat depressed. Each time the wound sealed over and ceased to drain she became very uncomfortable and had a rise of temperature. A catheter was inserted in the wound periodically to keep it open.

On October 13 she was taken outof-doors in the wheel-chair and that buoyed her up considerably. It was a beautiful autumn and the trip out-ofdoors was repeated every fine day. Following an elevation of temperature to 102 degrees on October 20, the lower part of the incision opened and drained bile freely.

On November 2 Mrs. S. was fluoroscoped and the tube could be seen, still in position. Contractions were less severe and less frequent. She was discharged from the hospital November 4, the wound still draining freely. She was gaining from one to one and a half pounds a week but otherwise there was little improvement. Each time drainage ceased she became nauseated and had a high temperature and was becoming very discouraged. This continued until a few days before Christmas when drainage suddenly ceased, this time with no ill effects. Jaundice had completely disappeared and her general condition was good.

I had hoped to report that she had passed the tube but x-ray early in January revealed that it had moved very little. This causes no concern; the tube may be retained for years. Adhesions form linking the hepatic duct with the stomach.

Home Economists' Convention

At the request of the Canadian Home Economics Association, attention is drawn to the conference to be held in Winnipeg, August 27-31, 1945. A glance at the list of

well-known authorities who have accepted the invitation to speak indicates a stimulating and vital program. Home economists from all over Canada are invited to attend.

Interesting People

Ruby M. Simpson, O.B.E., has retired from her work as director of nursing services, Provincial Department of Public Health, Saskatchewan, which position she has held since 1928. Only last year, Miss Simpson was a recipient of one of the three Mary Agnes Snively Memorial Medals, awarded for outstanding contributions to nursing in Canada.

Born and educated in Manitoba, Miss Simpson entered her training in the Winnipeg General Hospital after serving as a teacher in the Winnipeg public schools for five years. Following graduation she commenced her nursing career in Saskatchewan, first as public school nurse with the School Hygiene Branch with the Department of Education, then in 1920, as health instructor in the provincial Normal School, Saskatoon. Her talents received early recognition and in 1922 she became director of school hygiene for the province, leaving that post to assume her wider duties.

Throughout the years, Miss Simpson



RUBY M. SIMPSON

constantly gave of her time and strength to work with the nursing associations. For five years, she served as president of the Saskatchewan Registered Nurses Association, leaving this office for the broader field of leadership as president of the Canadian Nurses Association. The four years of her presidency, 1934-38, were rich in development under her sound guidance. It was during this time that Canadian nurses were honoured when Miss Simpson became an officer of the Order of the British Empire, civil division.

Miss Simpson's retiral to her beautiful home on Vancouver Island will provide her with full opportunity to devote her energies to her garden and her books. We wish her many happy years among her flowers.

Elizabeth Bell Rogers has recently accepted the position of registrar and executive secretary with the Alberta Association of Registered Nurses. Born in Weston, Ontario, Miss Rogers has records which trace her English and Scottish ancestry back to the fourteenth century. Educated in Ontario, she taught school for several years before entering the School of Nursing of the Royal Victoria Hospital in Montreal. Subsequently she prepared herself for teaching and supervision in schools of nursing at the McGill School for Graduate Nurses, graduating with marked distinction. After four years on the teaching staff at the Royal Victoria Hospital and a like period as director of the teaching department of the Ottawa Civic Hospital, Miss Rogers became the superintendent of nurses in The General Hospital, St. John's, Nfld, Immediately prior to moving west, she was superintendent of the hospital in Grand'Mère, Que.

Miss Rogers brings many unique gifts to her new position. In addition to her broad experience in schools of nursing, she has long been keenly interested in the work of provincial and national nursing associations. She served her apprenticeship on the executive of the Canadian Nurses Association while chairman of the Nursing Education Section of the Registered Nurses Association of Ontario. Her knowledge of association activities will prove a strength in her new work.

Being a well-rounded personality, not all of Miss Rogers' energies have been expended on the professional side of her life. She knows the lure of the out-of-doors and can handle a canoe in summer or a curling stone in winter. Antique furniture, reading, and knitting claim her interest indoors. The good wishes of her colleagues follow Miss Rogers to her new field of endeavour and her success in Alberta is confidently predicted.

Elizabeth Smith, B.A., has recently been appointed to succeed Ruby Simpson as director of nursing services, Provincial Department of Public Health, Saskatchewan, Of Scottish ancestry, Miss Smith was born in Ontario. Most of her preliminary education was received in Saskatchewan, including her university work. After having taught in rural public and high schools in Saskatchewan, Miss Smith commenced her ing career by entering the school of nursing of the Vancouver General Hospital. Following her graduation in 1926, she returned to her prairie home to take charge of the health department of the Provincial Normal School in Moose Jaw. This work included the supervision of the health of the student teachers and instructing in health education. Miss Smith was one of the early recipients of a fellowship from the Florence Nightingale International Foundation and spent a year studying public health nursing at Bedford College, London, England. She was president of the Saskatchewan Registered Nurses Association for three years and has always participated actively in nursing association affairs. Miss Smith has a keen mind and is very progressive and alert to all the new developments in her chosen field, which augurs well for the success of her department. We wish her well.

Marie Brigitte Laliberté, B.S., has recently returned to Montreal after re-



ELIZABETH B. ROGERS

ceiving her degree at Columbia University, New York, to assume the duties of assistant director of nursing services with the city health department. Born and educated in the province of Quebec, Miss Laliberté graduated from the St. Jean de Dieu School of Nursing in 1927. For two years she served as a head nurse at the Greystone Park Hospital, Morris Plains, N.J. When she joined the staff of the Montreal Department of Health she became particularly interested in the work of the mental hygiene division.



ELIZABETH SMITH



Garcia, Montreal
BRIGITTE LALIBERTE

With her other duties she has now become consultant in mental hygiene. Her interests extend to many branches of community and nursing organization activity and have included the presidency of St. Jean de Dieu Graduate Nurses Association, treasurer of District 12, R.N. A.P.Q., and vice-president of the nursing committee of "Le Bureau de la Jeunesse". An all-round person, Miss Laliberté enjoys her tennis and swimming. Her favourite hobby is drawing, though she is also an accomplished seamstress.

Mabel Thomson, a graduate of the Brantford General Hospital School of Nursing and the University of Toronto, has been appointed instructor of nurses at the Niagara Falls General Hospital.

Obituaries

The sudden death of Harriet J. Blanch, a graduate of the Saint John General Hospital and a member of the Class of 1913, occurred recently at Belfast, Maine. For a period of some five years Miss Blanch was first supervisor, then assistant superintendent of nurses at her alma mater, leaving to accept the position of superintendent of the Aroostock Hospital, Houlton, Maine, where she remained for twenty-five years. At the time of her death she was superintendent of the Waldo County Hospital, Belfast, Maine, and president of the Bundles for Britain Society. She was very active in Red Cross work and all patriotic endeavours as a part of which she lectured on the wartime needs of small hospitals in Maine.

Although she practised her profession principally on the American side of the line she never lost interest in her own School and whenever possible attended the annual dinner of the Alumnae Association.

Mrs. Bruce Boreham (Mary Shaver) passed away recently in Vancouver. Mrs. Boreham was a graduate of the Toronto General Hospital and a member of the Class of 1914.

Evelyn Edwards died recently. Miss Edwards was a member of the staff of the Metropolitan Health Committee, Vancouver, for twenty-five years and retired in October, 1944.

Mary Jane Gowdy passed away recently in North Vancouver at the advanced age of ninety-five years. Born in Richmond, Va., Mrs. Gowdy's family moved to British Columbia in 1850. After the death of her husband sixty years ago, she became interested in nursing and worked for many years in St. Mary's Hospital, New Westminster. When training schools for nurses were established in the province, Mrs. Gowdy was fearful that she might have to leave her chosen work. However, the provincial medical examiner, long familiar with her work, gave her a nurse's diploma, the only such certificate ever issued in B.C. to a nurse who had not gone through her regular training.

Mrs. Blaine Redfern (Donella Kinghorn) died recently in Toronto. Mrs. Redfern was a graduate of the Toronto General Hospital and a member of the Class of 1915.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

Conference Called by National Council of Women

At the closing session of the conference of representatives of Canadian Women's National Organizations called by the National Council of Women in February, 1945, and held in Toronto, the opinion was expressed that the forming of a program on which Canadian women can unite was a momentous step. The decision was made to call a second conference to meet May 3 and 4 for the purpose of drafting such a program, based on the recommendations that came forward at the first conference, and arranged by a special committee which the meeting authorized the chairman to appoint. The Canadian Nurses Association was represented by: Miss E. Cryderman, second vice-president; Miss N. Fidler and Miss Electa MacLennan, assistant secretary, C.N.A.

Visiting the Provinces

In an earlier issue of the Journal mention was made of the possibility of the general and assistant secretaries attending forthcoming provincial annual meetings. This objective has been achieved in several provinces thus far. Both the general secretary and editor of The Canadian Nurse were privileged to attend the annual meeting of the Alberta Association of Registered Nurses held in Calgary on March 26. Visits were also made to Edmonton, and opportunity was af-

forded to meet and discuss with various conveners of committees problems relating to nursing and nurses. The Registered Nurses' Association of British Columbia followed, with a two-day session early in April. While the Saskatchewan annual meeting will not be held until June, the officers very kindly arranged general meetings in Regina and Saskatoon, thus affording opportunity to meet many nurses in that province of widely scattered population. Manitoba followed with a two-day sessioin. The assistant secretary attended the Ontario annual meeting.

Although many and varied were the topics of discussion in each province, the similarity throughout was significant of the real effort on the part of nurses everywhere to meet the many demands being made upon them, both now and for the future.

British Nurses Relief Fund

Several provinces have continued to send funds collected for the British Nurses Relief Fund. In this connection we gratefully acknowledge the receipt of a donation of \$150 from the Trail Chapter, Registered Nurses' Association of British Columbia.

Extracts from letters received from British recipients have appeared in recent issues of *The Canadian Nurse*. They give some idea of the distress that bombing can and has caused in the lives of our sisters in Britain. Because of the steady V-bombing and increased air bombing

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during the latter part of February and March and the daily announcements of casualties in London and Southern England, the convener of the British Nurses Relief Fund requested the secretary to secure the opinion of the members of the Committee in reference to sending a further donation to Britain. It was unanimously agreed by the Committee that a further sum of \$5,000 should be sent to the Royal College of Nursing to be used as required.

Following is a financial statement of the Fund for the period October 15, 1944, to April 25, 1945: affairs, or are in possession of much misinformation on nursing affairs. In the brave, new world it would appear that we will not be permitted to go back into our splendid isolation. Being but one factor in the health cycle of a community, we will have to adjust our organization to fit in smoothly with the other organizations in a community concerned with health. We may even find very keen competition in the field of nursing itself. We are convinced that professional nursing service can only be given by professionally prepared people. The public are not prepared to support

Interest Ba	October 15th, 1944 ank ond			27.26	\$9,316.70
RECEIPTS: December, 1944 —	British Columbia. \$77. LESS Exchange	.89 \$7 1,0	714.31	1,714.31	97,010.70
	Miss Dorothy Gunn LESS Exchange		. 15	25.03	
February, 1945 — March, 1945	Saskatchewan		150.00	74.85	1,964.00
DISBURSEMENTS: April, 1945 —	D. LOW.	-			\$11,280.70
	Royal College of Nursing Exchange & Cable Charges	5,0	1.75		5,001.75
	Bank Balance Dominion of Canada Bond			• • • • • • • • • • • • • • • • • • • •	\$6,278.95 5,000.00
	Total Assets of Fund at April	25, 1945.			\$11,278.95

Publicity

During the past few years the nursing profession has, in spite of itself, been drawn into the whirlpool of community activity. No longer are we allowed to stand apart and consider only our own affairs in the light of our own needs. In this broadening process we have been constantly surprised to find that there are well-informed citizens who have only very vague ideas of nursing and its

this view. Why? Because they do not understand what is meant by professional nursing service.

The Canadian Nurses Association felt that the time had come to assume greater responsibility for giving to the public correct and adequate information on nursing. To this end, a short series of articles will appear in the daily press from Halifax to Victoria during May and June covering very briefly a history of nursing and the development of

the present day ideas of nursing education, the rise of the university schools and development of clinical graduate courses. The recognition of the importance of nursing by the Government is demonstrated through the federal grant, and we seek the support of the citizens of Canada in our endeavours to establish Practice Acts and in general to establish the professional status of nursing.

Legislation

At the recent session of the Manitoba Legislature, legislation was enacted to provide for the training, examination, licensing and regulation of practical nurses under the Provincial Department of Health and Public Welfare. Copies of the Bill may be obtained from the Provincial Department of Health, Legislative Buildings, Winnipeg.

Nightingale International Foundation

Mrs. Maynard Carter, chairman of the Provisional Committee of the F.N. I.F., arrived in New York in February, and after meeting with the members of the Executive, International Council of Nurses, visited Toronto where she conferred with members of the Canadian Committee (F.N.I.F.). A joint meeting of these committees was held in New York, May 4, at which Miss J. Masten,

convener, Miss F. Munroe, president, Canadian Nurses Association, Miss C. McCorquodale and Miss G. M. Hall, general secretary, represented the Canadian Nurses Association. Miss E. K. Russell and Miss Jean Browne represented the Canadian Red Cross Society.

Bursaries

Since the last report issued in March, 1945, awards for long and short-term bursaries have been made as follows:

Long-term: (Alberta) Marjorie F.

Davies, Medicine Hat; (Saskatchewan)

Sylvia B. Hagen, Loreburn.

Short-term: (British Columbia) Brenda D. M. Carter, White Rock, subject to successful completion of registered nurses' examinations; Fanny A. Kennedy, Vancouver. (Manitoba) Helen L. Gracey, C. Mabel McCaskill, Winnipeg. (Nova Scotia) Anne C. Campbell, Inverness. (P.E.I.) Edith Hume, Charlottetown. (Quebec) Mildred M. Brogan, Anna A. Christie, Marion E. Nash, Hilda Nuttall, Mabel A. Russell, Sr. Edmond du Saveur, Montreal; Sr. Luc de Sainte-Marie, Sr. Marie Majella, Sr. Marie-Paul, Sr. Marie du Precieux-Sang, Sr. Therese d'Alencon, Quebec.

Long-term bursaries issued in 1944-45 125

Short-term bursaries issued in 1944-45 71 Total 196.

Annual Meeting in British Columbia

The thirty-third annual meeting of the Registered Nurses Association of British Columbia was held on April 6 and 7, 1945, at St. Paul's Hospital, Vancouver. There was a record attendance of more than two hundred and fifty members. Fifty-four members from twenty centres outside Greater Vancouver area were present. Miss Gertrude Hall and Miss Margaret Kerr were hon-

oured and welcome visitors. Miss Grace Fairley presided at the five sessions.

Following the invocation given by Rev. Charles Murphy, a minute of silence was observed in tribute to those of our members who had passed on during the year, to members in the armed forces overseas and with UNRRA, and to those who are anxious for or have lost relatives in the war. Greetings

were extended by Dr. A. K. Haywood for the B. C. Hospitals Association and by Dr. G. A. Matthews, president of the B. C. Medical Association. Messages of greetings were read from Miss Munroe, president, Canadian Nurses Association, Miss Helen Randal, Miss Lyle Creelman, and Miss Frances Upton, for the Registered Nurses Association of the Province of Quebec.

In her presidential address, Miss Fairley referred to the challenge which the future will inevitably bring to nurses and to the Association and she quoted the watchword of the London Congress of 1909: "Life in its depth, variety and majesty - a very sweet and precious gift. Life of which we do well to gauge the value of single minutes - The mere passing of time is not Life". And added: "Surely in this day when life is so precious and vet apparently so cheap, when the passage of time - of every minute - is fraught with such epoch-making and historic events which will affect Life for centuries to come, we might well ponder over our Founder's Message".

In the Friday evening session, the members were privileged to hear two addresses - "Bridges to the Future" by Miss Gertrude Hall and "Over the Editor's Desk" by Miss Margaret Kerr. Miss Hall pointed out that millions of men in the armed forces of Canada and the United States have been receiving the advantages of modern dental and medical care and will not likely be content with anything less and suggested that their demands will hasten the coming of compulsory health insurance. The advances and changes made in nursing education during the war years, in the United States, Great Britain and Canada were reviewed. Miss Hall stated that the developments of placement service would seem to be one of our greatest achievements during the past five years. In this field of activity, British Columbia has led the way. Among urgent needs listed are more general publicity on nursing, representative study groups on and experimentation in nursing education, and for nurses to take their place as citizens. Miss Kerr commented on the rapid growth of The Canadian Nurse and told of present and future plans. She urged that more British Columbia nurses send articles and gave a preview of articles soon to appear.

The executive of the Vancouver Chapter were gracious hostesses at a luncheon in the Vancouver Hotel. The guests included Miss

Hall, Miss Kerr, Chapter and District delegates and members of the Council. The Friday afternoon tea in the Hotel Georgia, in honour of our guests, was a pleasant interlude in a busy day.

On Saturday afternoon, a round table discussion, "The Practical Nurse", led by Miss Aiberta Creasor, was held. Mrs. Paul Smith presented the community and family point of view and Miss Alice Wright outlined the characteristics of a licensing act and listed the immediate and future benefits which would result. The discussion which followed emphasized the need for a suitably prepared worker willing to take on some housekeeping responsibilities, in addition to the care of mildly ill, chronically ill or convalescent patients.

All committee reports were interesting, and evidence increased committee activity. In the report of the History of Nursing Committee, Miss Mabel Gray told the story of the collection of material for the History of Nursing in Canada, now in preparation, and supplied interesting biographical data on the author, Mr. J. Murray Gibbon.

Miss Esther Paulson reported the work of the Joint Study Committee on Health Insurance (representing the Medical, Dental, Pharmaceutical, Hospitals and Nursing Associations) and the progress made on the study of nursing needs and resources. Miss Fairley indicated the use made of British Columbia's allotment of \$18,000 for student recruitment and training and of the \$9,000 for bursaries for post-graduate courses. Twenty-three R.N.A.B.C. members received bursaries. Among the activities of the Placement Service Committee, Miss Mallory listed the investigation of existing hospital insurance schemes, which resulted in the acceptance of the R.N.A.B.C. as a member group of the Associated Hospitals Services and the enrolment of 174 members; a study of superannuation plans; initiating a course of "Techniques of Counselling" which was offered by the Extension Department of the University of British Columbia and was open to all members; and a revision of the organizational structure of placement service. The convener of the Press and Publications Committee, Miss Janie Jamieson, referred to the generous publicity accorded the R.N.A.B.C. by the press and the gratifying increase in British Columbia Canadian Nurse subscribers. A study of exemptive clauses designed to protect nurses compelled

to join unions was made by the committee on Labour Relations as reported by Miss M. MacLennan. The main activity of the Legislative Committee, convened by Miss Alberta Creasor, was concerned with publicizing the need for licensing practical nurses.

At the Public Health Section meeting the results of a study of legislature as it refers to the problems of tuberculosis in Canada was read by Miss Pauline Capelle and created considerable discussion. The Hospital and School of Nursing Section has decided to sponsor an institute on "Head Nurseship" in the Fall, to be held in several centres. At the meeting of the General Nursing Section members reported that staff conferences had been helpful in solving problems within their own institutions.

Miss Braund's report of the work of the Provincial Placement Service indicated that the recommendations regarding salaries and working conditions, approved by the R.N. A.B.C. and B.C. Hospitals Association, have had a gratifying effect in improving conditions for hospital nurses. The director has travelled widely throughout the province and has talked to graduate and student groups on the objectives and work of placement service. Records indicate a steady increase in number of private duty calls, with a greater increase in number of unfilled calls.

The registrar reported an increase of 66 students in the schools of nursing and a total of five hundred new members. Twenty-three students received bursaries from Dominion-Provincial Youth Training Plan Funds.

The reports of Districts and of Chapters in unorganized districts showed a great increase in activity and a broadening of interests. Four new chapters have been formed within the year, bringing the total to thirty.

With the election of 1945-47 officers, the primary objective of the recent revision of the Registered Nurses Act is fulfilled, i.e.; district representation on the Council. The personnel of the Council is: president. Evelyn Mallory; first vice-president, Elinor Palliser; second vice-president, Elizabeth Clark; honorary secretary, Esther Paulson; honourary treasurer, Edith Pringle; immediate past president. Grace Fairley: section chairmen: General Nursing, Elizabeth Otterbine; Hospital and School of Nursing, Emily Nelson; Public Health, Trenna Hunter: councillors: East Kootenay District, to be appointed; West Kootenay District, Margaret Heeney; Kamloops-Okanagan District. Olive Garrood; Greater Vancouver District, Lois Grundy, Katherine Lee, Elizabeth Copeland: Vancouver Island District, Margaret Baird, Myrtle Rondeau.

ALICE L. WRIGHT

Executive Secretary, R.N.A.B.C.

Blood Flown to the Wounded

Combined figures on east and west coast flights of whole blood to the war theatre has reached 193,000 pints. Since the start of the blood-flying program over the Atlantic last August, 150,000 pints of whole blood have been flown from the east coast to the European theatre. This service has made it possible for a wounded man to get blood within 'wenty-four hours after it was drawn from a donor here. Shipments now average about twelve hundred pints a day, which provides transfusions for three to four hundred average cases. Whole blood shipments being flown from the west coast to the Pacific Ocean area have totalled 43,000 pints since the inauguration of the service last November.

Whole blood keeps in condition for trans-

fusions five days longer than formerly, or as long as twenty-one days, because of a new system of refrigeration which has been inaugurated. The bottled blood is now being flown overseas in compact, expendable ice-boxes made of metal foil on cotton insulating board which keep the blood within safe temperatures: between 39 and 50°F. The containers, measuring 21 x 21 x 25 inches, weigh only 105 pounds when carrying their full capacity of twenty-four bottles. Each bottle contains about a pint and a half of whole "O" type blood. Continued donations of type "O" whole blood are necessary to maintain this life-saving service.

Office of the Surgeon General Technical Information Division Washington, D. C.

Nursing Education

Contributed by

COMMITTEE ON NURSING EDUCATION OF THE CANADIAN NURSES ASS'N.

Post-Graduate Courses in Clinical Supervision

These are courses offered primarily for preparation for the position of hospital head nurse or clinical supervisor. Such positions demand a combination of nursing, administrative and teaching abilities. The head nurse is not only the administrative head of the ward, and the person responsible for the nursing done in it, but she is usually also a member of the teaching staff of a school of nursing. For the adequate preparation of such a nurse, there seems to be required a course which will combine instruction in the general principles of supervision and administration, in educational psychology and teaching methods, and advanced instruction and thorough study and practice in nursing in one of the major clinical fields.

This last emphasis, on nursing itself, has come to be considered increasingly important. We have complained for a long time that the head nurse did not teach enough because she had too many administrative duties and because she was not trained to teach. Now we realize that the trouble has often been, not solely that she did not have time and did not know how to teach, but frequently also that she did not know what to teach. The head nurse frequently has gone no further in nursing than her students are expected to go. It will be obvious that this is unusual for a teacher who, in most educational fields, has mastered a far greater content in her subject than she expects her students to do.

For this reason, that a real study of nursing in the particular field should be an important part of the preparation of the head nurse, it seems desirable that the applicant for a course in clinical supervision should choose one definite clinical field in which to make this study; that is, she will take a course in medical supervision, obstetrical supervision, or some other specific field. This does not mean that the graduate in, e.g., medical supervision. should hesitate to take a position in another clinical field. She is obviously much better prepared for any supervisory position than the nurse with no special training. The instruction in supervision and in teaching will be the same for all these courses, but, with this, the nursing content of one field will be sufficient for eight months' work.

Several of the university schools of Canada now offer courses in clinical supervision. In some it is possible, though not desirable, to take half the course in one year, and the remainder in the second term of a succeeding year. As an example of the way in which these courses are organized, the following outline of one is given:

The course commences in the autumn term with a two weeks' orientation period in the university in which the work of the year is outlined, reading is assigned, methods of study discussed, and the student prepared for the first unit of field work. A block of six weeks is then given to nursing practice in the clinical field chosen. Here emphasis is not only on revision of techniques, but also on attaining a broader conception of nursing (including the health and preventive and social aspects), and especially on

the planning of nursing care for individuals and groups. After this, the student returns to the university classroom for three months of intensive study in nursing, supervision and administration and teaching. Again she returns to the hospital for two months of field work, which this time consists of practice in clinical teaching and ward adminis-

tration. The course concludes with two weeks at the university for conference, review, and examinations.

In next month's issue of the *Journal* available courses in clinical supervision will be listed with other post-graduate courses.

Ontario Public Health Nursing Service

The senior nurses of the seven County School Health Programs recently attended a conference and round table discussion with the director and supervisors of the Division of Public Health Nursing. This is the first time that this group has met together since six of the County programs have come into existence during the past year.

Mrs. Frances Lindsay (Ferris), B.Sc.N. (Toronto General Hospital and University of Western Ontario degree course in public health nursing) has accepted an appointment with the North York Board of Health.

Mrs. Dorothy Hawkins (Hare) (Toronto General Hospital and University of Western Ontario public health course) has accepted an appointment with the Middlesex County School Health Unit.

Elma Ward, B.Sc.N. (University of Western Ontario and Victoria Hospital, London) has resigned her position with the Welland Board of Health to be married.

The following graduates of the public health nursing course at the University of Toronto have accepted appointments: Evelyn Cunningham (Brantford General Hospital) with the Brantford Board of Health; Winifred Hay (General and Marine Hospital, Collingwood) with the Kingston Board of Health; Bernadette Walsh (St. Joseph's Hospital, Peterborough) with the Guelph Board of Health; Margaret Wright (Toronto Western Hospital) with the Haileybury Board of Health; Mary Kiemele (Nia-

gara Falls General Hospital) with the Stamford Township Board of Health; Margaret Roberts (Toronto General Hospital) with Hamilton Department of Health; Kathleen Abbott (Wellesley Hospital) and Patricia Phillips (St. Joseph's Hospital, Toronto), with the Simcoe County School Health Unit; Mrs. Jean Rhoten (Toronto Orthopedic Hospital) with the Pickering Township Board of Health; Mrs. Mary Fraser (University of Iowa School of Nursing) with the Division of Epidemiology of the Ontario Department of Health.

The following graduates of the public health nursing course at the University of Western Ontario have accepted appointments: Margaret Drummond (Victoria Hospital) with the Cochrane Board of Health; Julienne Gagner (St. Joseph's Hospital, Chatham) with the Porcupine Health Unit; Jean McEwan (Brantford General Hospital) with the Kitchener Board of Health: Dorothy Ball and Ruth Burney (Victoria Hospital, London) with the Kirkland-Larder Lake Health Unit; Ruth Weekes (Toronto General Hospital) with the Fort William Board of Health; Mary Love (Stratford General Hospital) and Gertrude Bridgette (Hamilton General Hospital) with the Hamilton Board of Health; Aileen Ogilvie (St. Joseph's Hospital, London) with the Owen Sound Board of Health; Joyce Hankinson (Brantford General Hospital) with the Sarnia Board of Health for the summer.

Cliders Carry Wounded to Hospitals

A glider service had been inaugurated in the European Theatre to evacuate wounded men. Observers reported that the shock incident to being "snatched" into the air was absorbed by an improved towing device. It is now possible that gliders may almost eliminate ambulances for hauling our battle casualties long distances over shell-torn roads, giving them a faster, smoother ride to the hospital. The gliders serve a dual purpose. Coming right into the battle area they can carry twelve litter patients or nineteen walking wounded. Ambulance gliders were first used experimentally by the British in Burma and New Guinea.

-Technical Information Division

Postwar Planning Activities

Contributed by

POSTWAR PLANNING COMMITTEE OF THE CANADIAN NURSES ASSOCIATION

The Opportunities and Needs for Supervisors in Public Health Nursing

During the past twelve months and longer, the health of the people has received marked attention in the legislature of every province. Progressive legislation dealing with health matters has been enacted, while on the county and local levels officials and citizens generally are discussing seriously how they may secure more adequate health services. The establishment and development of services in some provinces has been delayed for lack of qualified personnel, public health physicians and nurses as well as sanitary inspectors. There is reason to expect that the cessation of hostilities on the European fronts will have an effect upon this situation. Even allowing a period of time for graduate preparation it is not too soon to concern ourselves about leaders (supervisors) in nursing.

Writing in the January number of the The Canadian Nurse Mildred I. Walker said: "Supervision is now considered as guidance, the aim of which is to promote increasing growth in those supervised. To practise the principles of guidance most effectively one must be truly democratic." It is suggested that Miss Walker's article be re-read and also the continuing one in the February Journal for they have an important bearing on the subject under discussion here.

If Canadian citizens are demanding health services, and there is ample evidence that many are doing so, then professional nursing must accept some degree of responsibility for the provision of adequately prepared personnel to meet the needs of Canadian communities. Each health service unit, official or unofficial, according to the number of its staff, should have one or more supervisors if the people of the area are to receive the best possible service and if the staff members are to have the opportunity for growth through practice in the planning and developing of the program. Such experience will increase the quality of their guidance to the community, the family and the individual,

Nursing shares with other professions in the health field this need for leaders and its corollary the opportunity for service. The preparation may entail some degree of inconvenience, even sacrifice, on the part of individual nurses. This factor should be reduced to its lowest terms through the action of our national and provincial associations as well as the employing agencies. These groups know the promising young nurses on their staffs who, with the challenge of today's needs, can be called upon to accept greater responsibilities provided the possibility of securing preparation is within sight and reach.

No data are at hand regarding needs in the various provinces or in the unofficial fields. It is suggested, however, that at the provincial level the postwar planning committees might with advantage secure such information and present it not only to their own associations but to their provincial departments of health and to universities offering graduate courses in nursing, and with these representatives consider practical steps to meet the situation.

The importance of leadership should need no supporting argument to the members of this generation. The leaders of the allied countries, in spite of toil, carping criticism and misunderstanding, have given of themselves freely in the cause which claimed their loyalty. Surely sober judgment must affirm that they are serving their generation. The challenge to public health nurses now is that they should do likewise in their own sphere.

EDNA L. MOORE

Convener, Committee on Postwar Planning, Registered Nurses Association i Ontario.

We Climbed a Tree

MARGARET PRINGLE

When lost, a New Brunswicker climbs a tree to get his bearings, then spots a taller tree on higher ground and makes his way to that for a view of a larger area. When the New Brunswick Association of Registered Nurses decided to initiate a Nurse Placement Service and the committee found themselves in a wood they decided that the tallest tree in sight was the set-up of the Provincial Placement Bureau of British Columbia. That plan of organization was tentatively adopted with some changes to adapt it to local conditions, and the work of organization was begun. Now from the vantage ground of six months' experience we can outline the success we have had, some of our failures, and can see new objectives,

Publicity which was needed immediately included some newspaper releases, field contacts and direct personal correspondence. Enrolments, co-operation and sympathetic understanding on the part of the nurses was sought first. Soliciting applications from possible employers was intentionally postponed until we could build up a certain backlog of nurses seeking new positions. But events do not wait and the calls for nurses came in much more rapidly than the enrolment of position-seeking nurses. Nurses were urged to enrol at once so that their biographies could be built up, credentials prepared, and their qualifications studied to prepare for the time when the nurse might be ready for a new position.

Enrolments were slow. Acceptance of the Service was wholly voluntary and the thought of using an intermediate agency when seeking a new position was so new that the idea needed some time to germinate. During the first six months, approximately 9 per cent of the membership of N.B.A.R.N. (exclusive of Religious Sisters) has enrolled, These are chiefly nurses who have the experience and insight to see its value. An increasing number of enrolments have been coming in recently from nurses with the armed forces. One hundred per cent enrolment is necessary for 100 per cent efficiency of operation.

Placements have been few. Since the object is to stabilize the nursing service of the province, it has been our policy to encourage nurses to remain in positions where they are needed and where they are giving satisfaction to employers unless a change would mean that the particular qualifications of personality, education and experience of the nurse would be utilized to better advantage to her and the public. Few nurses are seeking positions today. New graduates are absorbed immediately.

Immediate needs would seem to be to secure: (1) The confidence and cooperation of the individual nurses, especially those who are within the working age; (2) information regarding fields of employment for the nurse who is handicapped by age, poor health or family responsibilities, often accompanied by geographical isolation; that is, the nurse who is willing to work but can give only part-time or partial nursing service.

Nurse Placement Sérvice is a service for the nurse. The individual nurse may strengthen it by enrolling and by starting her biography in our files. It can be supplemented as time goes on so that everything will be ready when she decides to make a change. If every enrolled nurse will notify us when she makes application for a position of which she may have learned through some other source, we will send her credentials, including recommendations from former employers. Identifying herself with her professional organization indicates to the discriminating employer that she is secure in her relationships with her peers, that is, that she "is in good standing" and that her record of past performance is open for inspection. It will also encourage lay employers to look to the professional organization for an evaluation of the nurse. We would

also be very grateful for any information regarding new or possible opportunities for nurses.

Nurse administrators may strengthen the service by registering not only their immediate needs but their plans for expansion. Enlarged physical plants and increased services require not only an increase in the number of the nursing staff, but new nursing positions may emerge which may require special preparation on the part of the nurse.

Viewed from our present tree-top the possibilities increase. The members of the Nurse Placement Service Committee have been made the Postwar Planning Committee under another convener thus enabling them to avoid unnecessary overlapping of activities. Future developments might include closer relationships with other placement services, extension of the service to include the subsidiary nurse or aide, and an effective co-operation with other community agencies. Six months has shown that to be effective the Service must be a long term project, for understanding of its functions and faith in its practical value must be built up. The horizon recedes and untouched fields come into view.

Bromism

(Continued from page 446) ing fluids are given freely and also nourishing food. It is usually necessary to spoon-feed the patient until the acute stage has subsided. Enemata and catheterizations are frequently necessary.

As soon as improvement is shown and interest is beginning to return, some occupation fitted to the patient's limited capacity should be encouraged. Diversions such as reading, crafts and music come first, then group activities. These activities are more beneficial and have more therapeutic value if they are arranged to use his previous skills and mental activities.

The final part of the treatment concerns the social aspect of the patient's life. Some adjustments may be necessary in order to make the environment to which he is to return more conducive to better mental health, and also to prevent a recurrence of the situation which required sedatives or so-called nerve tonics in the first place.

Much of this care and treatment would be eliminated if the nurses were alert and observant in their health teaching programs. Strong emphasis should be placed on the teaching of patients and other persons that any patent medicines dangerous and many are dangerous. Many persons could be saved the unnecessary expense and experience of being admitted to a psychiatric hospital if adequate control over the use of preparations containing bromides were provided by law.

STUDENT NURSES PAGE

Nursing Care in Typhoid Fever

THELMA MACKINNON

Student Nurse

School of Nursing, Royal Jubilee Hospital, Victoria, B.C.

The boy was admitted to our hospital on August 27, 1944. A lad of fifteen, his condition on admission was apparently very ill. A chill with rise of temperature to 104°, followed by profuse diaphoresis, occurred soon after admission.

He complained of general malaise, dull and persistent headache, pain and tenderness in the right kidney region and some pain in the right lung base on deep respiration. Also, he gave a history of having felt "under the weather" for almost two weeks previously. Gradually increasing malaise, intermittent headaches, and spasmodic epigastric pain had been troublesome.

Physical examination showed an enlarged, palpable spleen; slow, fairly regular pulse; tongue heavily coated white in centre with red, clear edges and tip.

A diagnosis of typhoid fever was made on the basis of these findings. This is an acute infectious disease caused by the bacillus typhosus, characterized by hyperplasia of the lymphoid tissues — especially enlargement of the spleen, and enlargement and ulceration of the "Peyer's Patches"; and accompanied by fever, headache, and abdominal symptoms.

The source of this disease is man the organisms are found in the blood during the first week of the disease and after the first week are present in the urine and stools. It is spread usually through contamination of water, milk, or food supplies with urinary or fecal discharges from an infected person.

Our patient had apparently contracted the disease through drinking infected water. He had been hiking through some woods about two weeks before and remembered stopping to drink from a small creek on the way. As far as known, this was the source of his infection.

During the first week, the boy's temperature averaged 101°, rising to a peak of 103° daily, usually in the evening. Pulse rate of 84, strong, bounding quality. Occasional nausea and headaches. Stools and urine of normal appearance. A leukopenia was present, white blood count being 3800.

The second week showed increasing weakness and lethargy, burning pains in the abdomen accompanied by frequent passages of soft stools containing "rice-like" particles. Bacillus typhosus was isolated from the blood culture. Widal reaction was positive for typhoid "O". The temperature averaged 101°, with daily elevations to 103°. Pulse rate 76 — 96, fairly good quality.

These symptoms continued through the third week with increase of abdominal pain. Lips cracked severely from the constant fever; with no appetite the patient was weak and listless. Diarrhea was marked, slimy brown or greenish stools, each containing numerous mucous particles.

During the fourth week the patient became extremely weak with anorexia and severe, persistent abdominal pain. The daily remissions of temperature became sharper — rising to 104° and falling to 100°. Frequent passages of curdled, greenish stools in which flecks of bright blood were seen. Pulse rate up to 110 at times, bounding quality.

The fifth week showed an increased lethargy to a state of stupor at times, with occasional periods of violet delirium due to the absorption of toxins. Temperature was higher, ranging between 102° to 105°. Pulse rate 120 — 142, rapid, weak and irregular. Respirations increased to 28 at times, very shallow. Frequent epistaxis and passages of large amounts of bright blood per rectum. Severe pain, and abdominal distention and rigidity preceded these rectal hemorrhages. The boy became terribly emaciated and his condition grew steadily weaker.

During the sixth week the boy's condition was weak to the point of death. There seemed very little hope that he would live. The temperature ranged between 100° and 105°, rising and falling sharply each day. Pulse rate of 130 — 150, very irregular. Respirations 28 to 42, shallow and weak. Almost continual delirium, constant muscular twitchings of the face and limbs and, larer, long periods of coma alternating with attacks of noisy irrationality. Severe abdominal pain and distention was always present and the rectal bleeding continued day after day. The boy finally became so utterly weak that it was imperative for him to have complete rest if he were to live, which at this time seemed very doubtful. Therefore we moved him only when absolutely necessary. Due to this enforced inertia a pressure sore developed at the base of the spine, in spite of all we could do to prevent it. However this later cleared up satisfactorily when the patient again became strong enough to endure more frequent changes of position.

During the seventh and eighth weeks a very gradual change for the better occurred, although extreme bodily weakness, mental and emotional instability of course persisted. The rectal bleeding ceased, the temperature gradually became normal, the pulse slower and stronger and the appetite improved steadily. A slight lung congestion and aching of the right ear were troublesome for several days but these complications did not become serious.

Convalescence proceeded well from the ninth to the twelfth week, although very slowly, of course, after so devastating an illness. During the thirteenth week our patient was able to be out of bed for a short time each day. His strength increased and he was discharged from hospital at the end of the fifteenth week.

This boy's prolonged illness tested our nursing care to the utmost. During the greater part of the fifth, sixth and seventh weeks his condition was so dangerously close to death that only the most imperative nursing procedures could be carried out.

Isolation technique was used throughout the long illness, with careful attention to the disinfection of all excreta. Absolute rest of body and mind was encouraged. The patient was fed until convalescence was well established. Fluids, chiefly milk, were given in the early stages, with very gradual and careful addition of non-irritating solid foods as the temperature fell and nausea disappeared. Very frequent cleansing of the skin and mouth were necessary. Saline enemata were given every other day during the fifth, sixth and seventh weeks to combat the distention and diarrhea. The extremes of temperature were controlled with hot sponges. Transfusions of whole blood were given every other day during the seventh week, approximately 250 cc. each time, to compensate for the rectal bleeding.

Medications used were: vitamin B and C capsules during the fourth to

twelfth weeks; sulphaguanidine gr. $7\sqrt{2}$ q.4.h. during fourth to fifth weeks; morphine gr. 1/6 - 1/8 hypodermically p.r.n. for pain and restlessness during the fifth, sixth and seventh weeks; phenobarbital gr. 1/2 t.i.d. during the sixth to tenth weeks, and hematinic capsules t.i.d. during the seventh to twelfth weeks.

This serious illness, which will without doubt adversely affect the boy's development for some time to come, could have been prevented through wider teaching and enforcement of sanitary measures. It would seem that there still remains much to be done, especially in regard to teaching and supervision, in the field of public health.

Book Reviews

You Are What You Eat, by Victor H. Lindlahr. 128 pages. Published by National Nutrition Society, Inc., New York, Price 50 cts.

Reviewed by Dr. L. E. Ranta, Assistant Professor, Dept. of Preventive Medicine, University of British Columbia.

Although the vehicle is radio-loquacious, it ultimately reaches the goal of a balanced diet, standing squarely on adequate quantities of proteins, energy-producing foods, minerals and vitamins; but the route is beset with the half-truths and unfortunate similes too often presumed necessary to create popular appeal. In the first part of his book, Diet-Broadcaster Lindlahr presents the thesis that, as we are composed of chemical substances assimilated from foodstuffs. our bodily composition may become unbalanced unless the various food components are consumed in certain definite proportions. Consequently, if we select our daily diet from prepared lists of protein, carbohydrate, and protective (milk, fruits and vegetables) foods in a weight ratio of 20-20-60, respectively; if our foods are properly prepared and vegetables and fruits are eaten raw whenever practicable; and if we avoid the "insidious evil", constipation, by selecting foods rich in hemicelluloses; if we do all this, we shall be healthier. Part II offers the prepared lists from which the daily diet should be selected. Other tables show the nutritive value of vegetables and fruits in terms of certain vitamins and minerals. Part III concludes the book by

dealing with each common fruit and vegetable under standardized headings: "selection and care," "preparation," and "best method of use" provide some useful information.

The text affords a few surprises. The implication is made that healthy persons differ in the manner of metabolizing starches and sugars. Cheese is reported to be constipating because its preparation alters the sponge action of the hemicellulose of milk! Also, the Lindlahr balanced diet is based primarily upon the fact that cellular metabolic processes must take place in a slightly alkaline medium. This leads to the conclusion that "alkaline-ash foods should comprise more than 50 per cent of the diet." In other words, no recognition is given to the well-known evidence that maintenance of the acid/base balance of blood and tissues falls most heavily upon protein buffer-systems.

It is obvious that the advice on the front cover, "Let America's Foremost Authority on Diet Show You How to Eat for Your Health's Sake," is meant for the layman. The book can do him no harm, but no reason can be found to recommend it as source material for the nurse interested in an educational program. The standard textbooks deal with nutrition more authoritatively, and "Canada's Official Food Rules" ably advise a balanced, adequate diet without superfluous hocus-pocus.

Psychotherapy in Medical Practice, by Maurice Levine, M.D. 320 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1944. Price \$3.50.

Reviewed by Helen M. McCauley, Assistant Supervisor, Allan Memorial Institute of Psychiatry.

The author, Dr. Maurice Levine, states in the Introduction to this book that he assumes that a physician who would want to read a book on psychotherapy recognizes the fact that psychological problems play a real part in medical difficulties. So, too, the nurses who will find this book of value are those who recognize the need for nursing the whole patient. To play her role in the doctor's plan of therapy, the nurse of today must have as thorough an understanding of man's emotional functioning as she has of his physical functioning.

The first chapter deals with common misconceptions in the fields of Psychiatry, Mental Hygiene and Child Guidance. Twenty-four prevalent misconceptions are stated and the comments which follow make easy and informative reading for everyone. Is heredity the chief cause for mental disorder? Does sexual experience cure psychiatric disorders? Is the ideal child always obedient? The answers brief, but adequate, are especially useful to the nurse who frequently finds she must re-educate her patient before she can begin positive treatment.

Methods of Psychotherapy used by the general practitioner are considered next. In this section the nurse may find the answer to why a doctor varies his usual routine for a specific patient. Many of the suggestions made to the physician regarding his attitude to, and relationships with, the patient are of equal importance to the nurse. The nurse uses various of the methods outlined daily: physical treatment, medical treatment,

hydrotherapy, hobbies, the giving of information, reassurance. Their full meaning to the patient is discussed — their psychological purposes as well as the other more obvious purposes.

Infant sexuality is considered in the part of the book devoted to sex and marriage. Marriage, its assets and its difficulties, is discussed, and some of the reasons for poor adjustments to marriage are commented upon. Everyone having centact with children will find "Basic Attitudes to Children" worthwhile reading. Dr. Levine states: "Many of the problems of children with which the general practitioner and pediatrician have to deal are fundamentally based on problems of the parents of the children, or on the problems of relatives or nursemaids". He then points out how unfavorable attitudes of controlling adults may cause children to develop symptoms of revolt expressed either in a physical fashion or in anti-social behaviour.

In conclusion the author outlines the criterion of emotional maturity and explains it in terms of everyday incidents. We are thus presented with an understandable and reliable yardstick for measuring our own normality and maturity.

References are mentioned in each section of the book for use of those who wish to study more fully that particular aspect and, in addition, there is a more complete list of suggested reading in the last chapter.

Though it is clearly stated in the Introduction that this book was written for the general practitioner, medical specialist, and medical students, there is much of value in it for nurses too. The clear manner in which the information is presented, point by point, makes the book particularly useful for student reference.

Dental Needs of Returned Soldiers

A redistribution station, where soldiers just returned from overseas receive dental treatment, has reported that about one man in ten needs an extraction or other emergency dental treatment. This includes the construction of a denture if the man hasn't enough teeth to chew an average meal. According to this report, about 45 per cent of the men returning from overseas need one

or more fillings while about 40 per cent do not require any dental treatment. Figures previously released show that about one man in every four requires emergency dental treatment at the time of induction.

> Office of Surgeon General Technical Information Division Washington, D. C.

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JUNE, 1945 475

Letters to the Editor

Dutch Children in England

It's high time I gave you some account of our activities since coming to England en route to our European assignment with UNRRA. We left New York about the middle of November. I wish I could tell you about the crossing but I am afraid all I should say is that we came in a large troopship and had a most interesting voyage. I should explain that by "we" I mean Miss Stephanie Szloch and myself. Stephanie was Nursing Arts instructor in a Boston hospital and the two of us are the only nurses from the other side of the Atlantic who, so far, have come to the London office of UNRRA.

We spent over a month in London finding lodgings — or perhaps I should say "digs" — getting registered at the police station and food office, doing some sight-seeing, and making what plans we could to carry out our assignment. Because of the military situation it was obvious that we would not be able to proceed further for some time. When we learned that plans were underway to bring over to England some Dutch refugee children from the liberated parts of Holland and that nurses were needed we volunteered to give some assistance.

The hostel where the first group is housed is near Coventry. It was left vacant by war workers and has been converted into rather convenient lodgings for the children. The physical set-up consists of an administration building containing the offices, dining hall, games room, and lounges; six blocks, each housing some eighty to ninety children; staff blocks; and a ten-bed sick-bay.

Four hundred and ninety-six children, ages seven to fifteen, arrived on the evening of February 11. The appearance of the children was not as expected, and the newspaper reports of the following day were somewhat misleading. I think they must have had their copy ready before they saw the children. They arrived cheering and singing and every one carrying a Dutch flag. They were a little weary from their four-days' journey and many were somewhat pale. Apart from that they did not present any obvious signs of malnutrition. However, we discovered later that the apparent age of the children was well below their actual age. It was in this respect rather than in actual thinness that the effects of their diet were noted.

The first job was to get them fed and to bed. All hands, including everyone on the hostel staff, members of the Women's Voluntary Services, and boy scouts; were ready to welcome the children and to assist. Everywhere one turned there were photographers and representatives of the press. The children seemed quite unaware of all this publicity and attacked their first meal in the hostel with great zest.

We knew very little about these children before they came and it was impossible to glean from books much information in regard to the feeding of the type of malnutrition we expected. We knew that their diet in Holland had been mostly bread, potatoes, and cabbage, and that the fat had been practically non-existent. Consequently, in order to avoid gastric disturbances, it was planned to limit the fat to 50 grams daily and the carbohydrate to 400 grams. We started at 1800 calories and at the end of the first week had worked up to 2400 calories daily. Very soon they were on a full diet and could have as much as they wanted to eat. Under wartime conditions, and the rigid food rationing in force in England, it is very difficult to plan well-balanced meals and also take into account the national customs of the group being fed. Some of the children were hungry at first. This was understandable when we learned that, although most of them had been brought to England because of lack of sufficient food, some few had been included who had always received an adequate diet, but who had been rendered homeless due to the flooding of parts of Holland.

The clothing of the children was in rather poor condition. Great sacrifices had been made at home to send the children over as well-dressed as possible. We heard of one family of nine children from which two were selected to come to England. The parents refused the offer because they would have had to take two of the four coats the children possessed leaving only two coats for seven children. Some were dressed in suits and coats made from army clothing given by the soldiers. Several had this military-appearing costume completed by British or Canadian Army insignia. The shoes were in the worst condition and many wore all-wooden clogs. The busiest people in the hospital for the first week were the un-



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School for Graduate Nurses, McGill University, Montreal 2

tiring members of the W.V.S. who fitted every child with a complete set of clothing. Many of the little girls refused to wear their new dresses at first. They were just too nice and they wanted them to wear home. This clothing was all supplied by American and Canadian Red Cross, and, incidentally, every bed is covered with quilt or afghan from the Canadian Red Cross.

The children were accompanied by a matron, leaders or "leidsters", and teachers. There was also a Protestant dominie and a Roman Catholic priest. The nursing staff already here was augmented by two nursing sisters from Holland. I would like to digress briefly from the story of the children to tell about one of these nurses. During the liberation of her home city her home was machine-gunned and burned, and she lost all her possessions. Just before coming to England she had been working in an underground hospital - not a hospital of the "underground" movement - but a hospital actually under the ground. It had been converted by the Dutch civilians from an air raid shelter built by the Germans for their S.S. police. This shelter had central heating, air conditioning, and its own electric dynamo. The latter, however, was always out of working order because it was built for the Germans by forced Dutch labour and was, of course, well sabotaged during the building. There was also a large telephone exchange capable of covering the whole of Holland and half of Germany. The police would thus be able to "listen in" on every call made in that territory. Unfortunately for the careful plans of the Germans they did not have time to make use of the exchange before the Allies liberated the area. The shelter accommodated seventy-two beds, the majority of them two-tier bunks with a gangway on one side. Many nursing difficulties were presented - shortage of soap and linen, giving nursing care to patients in bunks, and the fact that, due to shortage of electrical power, the lights were out for six hours during the day, thus making it necessary to do all the nursing in a much shorter period.

We expected more illness than at first developed. An advance message warned us to be ready to receive a possible appendix and an otitis media. Simple treatment and a



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night's rest soon effected a cure in both cases. The regulation of the diet kept gastric upsets down to a minimum. The clinic was the busiest part of the health service at first because many children had sores on their hands and feet, due mostly to the poor footwear and the lack of soap. Some of the adults brought with them a cake of the soap used in Holland. It was somewhat smaller than one of our ordinary cakes of toilet soap, dirty pink in colour, and filled with air. It was almost impossible to make any lather with it. This cake was the individual's month's supply for toilet use. Our troubles in the sick-bay were to come a little later, We are just recovering from an epidemic of infectious jaundice, are in the midst of an epidemic of mumps, and have two cases of diphtheria. But, considering that it is next to impossible to carry out any isolation precautions without admission to the sickbay, we have been very fortunate. Our original ten-bed sick-bay has been enlarged by crowding the beds and taking over a vacant end of a staff block.

Many of these children, especially the older ones, had been encouraged to resist enemy authority by the performance of acts of sabotage. We wondered what would happen here and how they would respond to discipline. A few did try such things, as letting the air out of the tires of staff bicycles, but on the whole they quickly respected the difference in their environment and responded well to hostel life and regulations.

There was very little homesickness among the group. Occasionally a little girl will be found silently crying because she is worrying about her father was was taken to Germany two or three years ago, or about the rest of the family at home who were living under very poor conditions. They can each send one card a week and the messages to the parents must give the latter a great deal of relief. They tell of the good food they are getting, how much weight they have gained (and they have gained, some as much as eighteen pounds, and many have quite outgrown the clothes they were given), the interesting places they have been, and how much they like England.

This group of children, only a few of whom are orphans, is the first of some twenty thousand who are to be evacuated from

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Disabled Soldiers Re-learn Driving

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Office of the Surgeon General Technical Information Division Washington, D. C.



Holland to England for a period of three months. At the end of that time some will return home but many will be placed with English families for a further stay. There is no doubt that as the groups continue to arrive more and more serious cases of malnutrition will be found.

One thing that worried us at first was how we would get along without any knowledge of the language. That was certainly crossing the bridge before we came to it. These children have learned a great deal of English from the soldiers and are very proud of this knowledge. In any small group it is always possible to find at least one child who understands what you are trying to tell them and can interpret to the rest. Our doctor is not Dutch but can speak their language very well. A little boy came to the clinic one day and the doctor began to converse with him. The little boy interrupted, "You don't need to speak Dutch. I speak English".

These children are just like any group of Canadian children. They are lively, mischievous, and happy, if the singing one hears continually is any indication. There is one quality more marked—self-reliance. It is probably a characteristic fostered by the nature of their life under Nazi domination and it is certainly a quality which is valuable when they are so far from their parents and cannot receive very much individual attention from their leaders.

Stephanie has already gone to another camp in Scotland where the third group of children are expected shortly, and I, being a victim of jaundice, am returning to London. It has been a very interesting experience and we are very glad that we have been able to be of some small service to the first group of evacuees to come from any liberated country.

-LYLE CREELMAN

Some Impressions of Scotland

Scotland, land of the bens and the moors, the glens and the lochs! The bens, in the fall and winter with their snow-capped peaks, are surrounded with a glorious bluish-purple haze. Later, as the seasons advance and the shrubs, bracken and heather come into their own, the colour tone changes. One sees here a patch of brown, there green, there purple, all harmoniously blended into a perfect picture.

The locks, some with small towns dotted

along the edge, some with mountains rising high on either side, on one side may be green and fertile with, perhaps, a shepherd's hut nestled at the edge; on the other side a mountain rises craggy and severe, with sparse patches of gorse and heather. To complete the picture and to make it really thrilling and awesome, all one needs would be to hear the skirl of the bagpipes high in the hills. The lochs, like people, can change their moods very quickly - one minute gay and sparkling in the sunshine, the next dark, dour and brooding, almost cruel-looking. How delightful it is to cycle around these lochs on a fine day - the gently undulating roads - the spring, summer and autumn flowers. First come the rhododendron with their glorious bright colours: next the primroses, followed quickly by the blue-bells, spreading their deep blue carpets everywhere. One never gets weary of following the same route time after time as each day brings a difference in colour tone and each turn of the road brings a new picture.

Then there are the walks on the moors wild, rugged and beautiful. On the edge or across it, through the heather, runs a narrow foot-path winding its way for miles. Here we come to a quaint stone bridge which is walled off in the middle to keep the sheep from wandering; again we come to a small gate something like a turn-stile through which one squeezes by stepping inside an iron circle, pushing the gate proper and stepping out on the other side. These gates are not built for the over-corpulent! Here again the scenery is almost impossible to describe. In July and August, when the heater is at its best, for miles on one side the purple blooms spread their carpet, interspersed with the tawny brown of the bracken. On the other side is a panoramic view of pasture, grain fields and gardens with farm houses in their midst. The next turn will bring a sight of the sea, over and behind which rise the mountains, one behind the other until one gets the feeling that they go on indefinitely.

Autumn comes quietly in Scotland — no sudden change from the summer green to the bright, almost garish, colours of our autumn. There one sees the gradual change from green, through the pastel shades until the leaves finally drop. One gets the same desire though to walk through the leaves and scuff one's feet. Does anyone ever outgrow that desire?





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The people of Scotland are the soul of hospitality. Just step inside the house and one is immediately "at home". Of course the very first thing a Scot's housewife does is to put the kettle on to boil for a "wee cup of tea" (which usually means three or four cups). The accent of the people in some parts is very hard for some of us to understand. In general, it is not so much the pronunciation of the words as the inflection and intonation that make the very great difference. Even on the bus, where the usual conversation is about queues, difficulty in procuring various articles, the number of coupons or points they have left. Jamie's sore knee or some one being taken to the hospital. the conversation never sounds drab or usual because of the natural lilt of their voices.

The favourite saying of the Scot seems to be "You can't miss it". When giving directions to a place they would describe so many turns left, so many to the right, and so many yards down to the left, ending with "You can't miss it" — which we invariably did. However, after spending over two years in Scotland I have a very warm spot in my heart for it and would not have missed the experience of living there for the world. Best of all, as far as a Maritimer is concerned, in spite of some differences, Scotland is like home.

-MATRON SHIRLEY M. BECK, R.C.N.

I have just returned from an eight-day leave which I spent in Scotland. It was nice to get away for awhile but I'm afraid we didn't get as much rest as we should have. Quite a lot of time was spent travelling. We saw Edinburgh, Glasgow, Perth and Aberdeen. Amongst the interesting sights was the Firth of Forth and the famous old Edinburgh Castle where Mary, Queen of Scots, and all the Scotch Kings and Queens lived. The castle stands in all its splendour on a high hill everlooking the city.

We also visited the Scottish Memorial built in commemoration of all Scots who died in World War I. It is said to be the most beautiful of its kind in the world and this I can well imagine because I was thrilled with its magnificence. The shrine is lovely, and in a casket is a scroll with the names of all Scots who died in battle. I couldn't help thinking of all the fine lads in the world who have already paid the supreme sacrifice in another horrible war which was never going to be. I only hope that, in do-

ing so, they will make it a better world for all people and that their sons will be spared the hell of another war.

I must tell you, too, of our visit to the Royal Infirmary of Edinburgh where so many surgeons go for post-graduate work. Muriel Sinclair and I bravely walked in and had an interview with the matron who was such a lovely Scottish lady. She arranged for us to sit in the gallery of one of the theatres and watch Professor Learmouth perform a thyroidectomy. I am sure the doctors and internes observing wondered who we were. The professor lectured all during the operation and it was something just to be able to say we had been there. He certainly performed the operation with skill and speed.

I hear from Caroline Dauk, a graduate from St. Elizabeth's, whose home is Annaheim. I am sure she could write a much more interesting letter of experiences than I because they get the casualties almost directly from the field. She is in Belgium.

We are quite busy now and I can't explain how much I enjoy nursing these boys. One is well-paid in satisfaction alone for all you are able to do for them.

- NURSING SISTER L. P. NEAL.

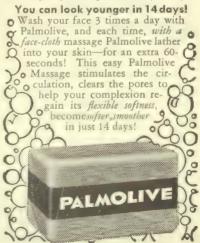
With UNRRA in Egypt

I have never regretted going with UNR RA. You do not realize until you are in it what a tremendous project it is and you often wonder if the spirit is big enough to succeed in an international mission. We were five weeks on the way from the U.S.A. to Egypt. We stopped a week in London to our great delight and saw all the sights - London Bridge, Westminster Abbey, St. Paul's, Tower of London. I was given also a ticket to the visitors' gallery in the Houses of Parliament while Parliament was in session. St. Thomas's is nobly carrying on using just the basement of the large hospital. I was ready to lay off my coat and put on my cap when I came upon a nursing clinic in the middle of a large public ward at St. Thomas's. The sister in charge was conducting the clinic with six probationers around the table. It was three o'clock in the afternoon. There was only one nurse left on duty and the twenty-eight patients in the ward were quite happy and did not ring bells nor flash lights to interrupt the clinic.

Our Mediterranean trip was lovely. The sea was as calm as a millpond. We travelled



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For further information apply to:

Miss Caroline Barrett, R.N., Supervisor of the Women's Pavilion, Royal Victoria Hospital, Montreal, P. O.

Miss F. Munroe, R. N., Superintendent of Nurses, Royal Victoria Hospital, Montreal, P. Q.

REGISTERED NURSES' ASSOCIATION OF BRITISH COLUMBIA

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Information regarding positions for Registered Nurses in the Province of British Columbia may be obtained by writing to:

Elizabeth Braund, R.N., Director Placement Service

1001 Vancouver Block, Vancouver, B. C.

on a deluxe liner and all was well. Egypt trips across the desert sand, adobe villages, hordes of filthy but cute children, Muezzin towers, palm trees, the pyramids silhouetted against the most gorgeous sunsets, then dark night and stars and a moon and a strange quietness. Alexandria is a beautiful city, Port Said dirty, Cairo colourful, very dirty in spots. Poinsettias, oleanders and roses bloom in gardens and along the boulevards. Tea in gardens under shady trees. The native bazaar - bargaining in Arabic with the shopkeepers, using my hands and getting along very well. It is easy to speak to the natives. You use one key word in English or French, if you know it, then use your hands and they understand.

The camp in the desert consisted of tents and huts, sand floors, shower huts and lavatories yards away from your sleeping tent. A batman wakens you at 6.30 with a cup of tea and hot water in your canvas bowl to wash. Prices in Cairo are exorbitant. A slip priced \$2.00 in Eaton's at home costs \$12.00, a pair of panties, \$8.00, skimpies at that, stockings, \$4.00 up.

-HELENA REIMER

NEWS NOTES

ALBERTA

PONOKA:

At a recent meeting of Ponoka District 2, A.A.R.N., Patricia Jamieson was elected president and Agnes Mitchell, vice-president, to fill vacancies made by members who have left the District. Miss Jamieson and Mrs. L. Stephenson were appointed delegates to the A.A.R.N. annual meeting. A raffle was held recently and \$60 was realized for the Camp Libraries Fund. Rosemary Russell, the winner, is a member of the post-graduate class in psychiatric nursing at the Mental Hospital.

Gertrude Hall, general secretary, C.N.A., recently visited the Provincial Mental Hospital. She spoke to the student nurses, giving them some of the highlights of National Office. Later she met some of the graduates and her visit was very much enjoyed by all.

and her visit was very much enjoyed by all.

The members who attended the recent course in "Administration in Small Hospitals" visited the Mental Hospital. They toured the hospital and had an opportunity

of observing special departments and therapies. Dr. R. MacLean, medical superintendent, and Dr. T. C. Michie, assistant superintendent by the control of the intendent, lectured on the admission and

care of psychiatric patients.

Barbara Beattie, superintendent of nurses at the Mental Hospital, is the newly-elected president of the A.A.R.N. Helen Furnell, who has left the District, has been replaced as supervisor of one of the infirmary wards by Phyilis Fraser.

EDMONTON:

Royal Alexandra Hospital:

The Royal Alexandra Hospital Alumnae Association banquet, in honour of the graduating class, was held recently with about two hundred present. We were very pleased to have G. M. Hall, general secretary, C.N.A., and M. F. Kerr, editor of The Committee Nurse with us. Miss Hall spoke briefly, depicting the ideals, responsibilities, and plans for nurses in the post-war world. She also brought greetings from Fanny Munroe, president, C.N.A., who was formerly super-intendent of nurses at the R.A.H., and now superintendent of nurses at the Royal Victoria Hospital, Montreal. Miss Kerr also said a few words to us. A congratulatory telegram was read by Violet Chapman, president of the Alumnae, from the alumnae members in Vancouver. We also received a letter from Mrs. R. Jensen (Cameron) who left for South Africa in 1939.

The toast to the King was given by Hilda Adams. Mrs. J. Rowlett proposed the toast to the Alumnae. Kay Stackhouse gave the toast to the graduating class which was responded to by L. Sangster. A. Woodhead proposed the toast to the members serving with the armed forces which was responded to by

N/S Emily Mayhew.

After dinner the R.A.H. Nurses Choral Club, comprised of students, under the direction of Mr. Alex Kevan, rendered several

musical numbers.

At a regular monthly meeting of the Alumnae Association, with V. Chapman presiding, plans were discussed for the Fall bazaar, the proceeds to go partly toward the scholarship fund and toward the general fund. A report of the A.A.R.N. annual meeting was given by Miss Chapman who was the alumnae delegate. Hazel Bishop, executive director of the Council of Social Agencies, gave an informative talk on the set-up and work of the Council.

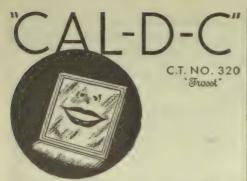
NEW BRUNSWICK

ST. STEPHEN:

At a recent meeting of the St. Stephen Chapter, N.B.A.R.N., the report of the executive meeting of the provincial association was given and all nurses were urged to register with the Placement Bureau in Saint John. The members voted to purchase a \$50 Victory Bond. Mrs. R. Rogers and







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CLARENCE W. TABER, Editor

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Price \$3.75; Indexed \$4.00.

THE RYERSON PRESS
TORONTO

Miss Mason were appointed to answer a questionnaire regarding the local registry. N/S Aldana Leland gave an interesting talk on her experiences overseas.

Nurses attended an evening service in May at the Presbyterian church as a part of a national observance in memory of Flor-

ence Nightingale.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Irene Weirs, Department of Public Health, City Hall, Fort William.

DISTRICT 1

LONDON:

A refresher course for the nurses of the various registries was held recently at the Institute of Public Health, University of Western Ontario. This course was realized through the Federal Government Grant. Twenty-one nurses from all parts of Ontario were in attendance and all felt that the course was most educational and instructive. "The Registry of the Community" and "Guidance in the Community Registry" were the topics under discussion.

DISTRICT 5

Toronto Western Hospital:

The following officers were recently elected by the Alumnae Association: honourary presidents, B. Ellis, Mrs. C. Currie; president, Mrs. G. Kruger; vice-president, G. Ryde; recording and corresponding secretaries, Mmes Townsend, L. Brown; treasurer, M. Patterson; committees: program, Mrs. Vale (convener), Mrs. Edwards, Miss Perry; budget, Miss Westcott (convener), Miss Scheetz, Mrs. Chant; social, Mrs. H. Brown (convener), Mmes Smeltzer, Mc-Kellar, Boadway, McDonald; sick benefit, G. Sutton (convener), A. Gillett, Mrs. F. Robinson; scholarship, A. Bell (convener), Mrs. Davies, Miss Lawless; visiting, Mrs. A. Norman (convener), Mrs. A. Clarke, E. Sinclair; Red Cross, Mrs. Douglas (convener), M. Agnew (treas.) Membership, Mrs. Chant (convener), Mmes McKellar, McMillan, Miss Thomas; representative to R.N. A.O., M. Agnew; Local Council, Mrs. G. Calder; W.P.T.B., Mrs. C. McMillan; The Canadian Nurse, E. Titcombe.

The association extends their heartfelt thanks to Mrs. D. Chant, the retiring president, who has been untiring in her efforts and has so ably led the association for the

past five years.

· The alumnae report revealed the following 124 knitted garments have been sent to the armed forces; 641 articles to the Birmingham Children's Hospital; 17 quilts were distributed to the Red Cross and Salvation Army; \$100 was contributed to the Chinese Relief; an oxygen tent was given to the hospital by the association.

hospital by the association.

The passing in South Africa of Mrs.
Robert Farkinson (Mary Sterling), a
T.W.H. graduate, was heard of recently.

Beatrice Ellis, former superintendent of nurses, was one of the guests of honour at the annual dinner of the R.N.A.O. held recently.

DISTRICT 10

PORT ARTHUR:

The first meeting of the public health nurses of District 10, R.N.A.O., was held at the Public Health Office and the second meeting took the form of a dinner. Mrs. Gladys Ward, Port Arthur, is the chairman, and the secretary is Violet Weston, Fort William. At the first meeting Bessie Jackson, of the V.O.N., Fort William, gave an interesting outline of her work in that city. A recommendation was passed to endorse any movement to establish a V.O.N. branch in Port Arthur. Twenty-two were present at the dinner meeting when Mr. Fred Mills, superintendent of the Children's Aid Society in Fort William, was guest speaker.

OUEBEC

MONTREAL:

Royal Victoria Hospital:

The annual dinner given by the Alumnae Association in honour of the graduating class was held recently with two hundred present and ninety-one in the graduating class. Seated at the head table were the president, Winnifred MacLean, Fanny Munroe, head of the School, the speaker of the evening, Dr. W. W. Chipman, and the guests of honour. After the toast to the King, Miss MacLean welcomed the guests and the toast to the class of 1945 was proposed by Kathleen Stanton to which Alice Foster responded. Miss Munroe announced the prize winners as follows: Highest marks: Dorothy Ford, 1st division; Doris Boyce, 2nd division. General proficiency: Pearl Murray, 1st division; Ruth Curtis, 2nd division. Alexina Dussault Prize for best bedside nursing, Dorothy Blinco. Dr. Tremble's Prize, Madeline Cheney.

Dr. Chipman's address on Mary Queen of Scots delighted every one, after which a short reception was held and the alumnae members had an opportunity of meeting the new graduates.

P/M Janet MacKay, of Sussex, N.B., was in Montreal for the alumnae dinner.



for infant's simple constipation, teething fevers, stomach upsets. A boon to mothers and nurses as an evacuant in the digestive disturbances which often accompany teething er which sometimes follow a change of food, where prompt yet gentle elimination is desirable. Sympathetic to baby's delicate system. No opiates of any kind. Over 40 years of ever-increasing use speak highly for their effectiveness.

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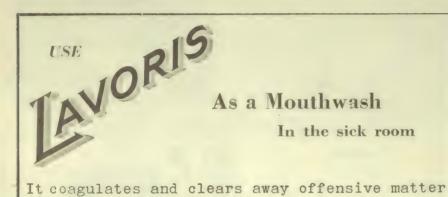
One Science and one Practical Arts Instructor are required for the Victoria Hospital, Prince Albert, Saskatchewan, for September 1, 1945. The salary is \$150 per month, with full maintenance. Four weeks vacation and four weeks sick leave with pay each year. Apply, stating particulars, age, and qualifications, etc. to:

Mrs. J. S. Harry, Supt. of Nurses, Victoria Hospital, Prince Albert, Sask.

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The Home Hospital, beautifully situated on Victoria Ave., St. Lambert, P. Q. Near Montreal; ideal for doctor or nurse. Six beds; room for enlargement; equipped for Obstetrical or Medical cases. Good clientele. Oil furnace; electrical stove; refrigerator. Owner retiring. Could vacate October 1. Apply to:

G. W. Clark, Real Estate, 236 Elm St., St. Lambert, P.Q. (Phone: 2883; Res.: 2767)



SASKATCHEWAN

During April the S.R.N.A. welcomed Gertrude Hall, general secretary, C.N.A., and Margaret Kerr, editor and business manager of The Canadian Nurse. as special visitors. They spoke at well attended meetings in Regina and Saskatoon, nurses coming from other parts of the province to be present. Miss Hall reviewed activities and developments sponsored by nurses throughout Canada. She made a strong plea for individual interest and for progressive thinking and action in a changing world. In her talk Miss Kerr placed responsibility for the support of the Journal at the door of every nurse. The immediate response was gratifying and we hope that subscriptions from Saskatchewan will increase considerably. Miss Kerr also met the senior students in schools of nursing in the two centres.

The organization of the Prince Albert Chapter has just been completed.

YORKTON CHAPTER:

The Chapter was recently addressed by Dr. C. J. Houston on "A Plan for Health Insurance". He urged the nurses to give serious thought to the study of all plans and to support only that which will give the best to the people of Canada. He urged nurses to guard jealously their high professional standards and to be ready to challenge anything which might jeopardize these

ses to guard realously their hight professional standards and to be ready to challenge anything which might jeopardize these.

N/S Margaret Simpson has returned to Yorkton after three years' service in South Africa. She reports having seen N/S Agnes Orr before leaving for Canada. N/S Simpson also worked with N/S's Charlotte Cook, Regina, and Betty Langstaff, Yorkton. N/S Lyle Newton (Appleton), who has been in England for the last three years, has also returned to Yorkton. N/S Newton was formerly instructor of nurses at the Queen Victoria Hospital. A shower was held at the home of Mrs. W. M. Bowan in honour of N/S Newton and a tri-light was presented to her on behalf of the thirty-five friends present.

WANTED

Vancouver General Hospital desires applications from Registered Nurses for General Duty. State in first letter date of graduation, experience, references, etc., and when services would be available. Eight-hour day and six-day week. Salary: \$95 per month, living out, plus \$19.92 cost of living bonus, plus laundry. One and one-half days sick leave per month accumulative with pay. One month vacation each year with pay. Note: The Hospital can obtain exemption for accommodation from Emergency Shelter Administration. The nurse is not exempt, excepting through employ of Hospital. Apply to:
Miss E. M. Palliser, Director of Nurses, Vancouver General Hospital,
Vancouver, B. C.

WANTED

Applications are invited for the following positions, with monthly salary as indicated: Floor Nurses, \$108; Supervisors, \$118; Night Supervisor, \$133—plus Cost of Living Bonus, \$4.50. From the above is deducted \$28 for room, board and laundry. After six months, appointment to the Hospital staff carries with it admission to the permanent Civil Service of the Province, with pension rights. Apply to:

Mrs. Grace T. Lewin, Supt. of Nurses, The Provincial Hospital, Saint John, N.B.

WANTED

Applications are invited immediately for the following positions in a 130-bed hospital in Western Ontario: Instructress of Nursing, with Post-graduate training in Teaching

Operating Room Supervisor, fully qualified

Apply in care of:

Box 6, The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P.Q.

WANTED

A Registered Nurse is required as Night Supervisor; three Registered nurses are also required for General Staff Duty. Eight-hour day and six-day Apply, stating salary expected, to: week, with full maintenance.

Superintendent, Shriners' Hospitals for Crippled Children, Montreal Unit, Montreal 25, P. Q.

WANTED

Applications are invited immediately for Staff positions with the Department of Public Health and Welfare, Halifax, Nova Scotia. Apply, stating qualifications, in care of:

Supervisor of Nurses, Department of Public Health & Welfare, c/o Dalhousie Clinic Bldg., Halifax, N.S.

WANTED

An Instructor and a Clinical Supervisor are required for the Port Arthur General Hospital. Bed capacity, 150; student body, approximately 50. Apply, stating qualifications and salary expected, to:

Miss A. Hunter, Supt., Port Arthur General Hospital, Port Arthur, Ont.

WANTED

A Director is required for the Social Service Department, Toronto General Hospital. Apply, stating qualifications and experience, to:

Miss J. M. Kniseley, Toronto General Hospital, Toronto, Ont.

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WANTED

Nurses are required for General Duty in the Verdun Protestant Hospital, Montreal. This is a splendid opportunity to obtain psychiatric nursing experience. State in first letter experience, references, etc. and when services would be available. Apply to:

Director of Nursing, Verdun Protestant Hospital, Box 6034, Montreal, P. Q.

WANTED

General Duty Nurses, registered or graduates, are required for the Lady Minto Hospital. The salary is \$90 and \$80 per month, with full maintenance. Apply, stating full particulars of qualifications, to:

Lady Minto Hospital, Cochrane, Ont.

WANTED

Two Registered Nurses are required for permanent Night Duty. The salary is \$90 per month, plus full maintenance. One full night off each week. Apply to:

Superintendent, Brome-Missisquoi-Perkins Hospital, Sweetsburg, P.Q.

WANTED

General Staff Nurses are required for the Allan Memorial Institute of Psychiatry, Royal Victoria Hospital, Montreal. Forty-eight hour week. The salary is \$100 per month, plus meals and laundry. Apply to:

Superintendent of Nurses, Royal Victoria Hospital, Montreal 2, P.Q.

WANTED

An Assistant to the Superintendent of Nurses is required by the Sherbrooke Hospital. Applicants must also be able to assist with the instruction for a rapidly-expanding English School of Nursing. Position available immediately. Apply, stating qualifications, experience, and salary expected, to:

Superintendent of Nurses, Sherbrooke Hospital, Sherbrooke, P. Q.

WANTED

General Duty Nurses are urgently required for a 350-bed Tuberculosis Hospital. Forty-eight and a half hour week, with one full day off. The salary is \$100 per month, with full maintenance. Excellent living conditions. Experience unnecessary. Apply, stating age, etc., to:

Miss M. L. Buchanan, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P. Q.

WANTED

Two Registered Nurses are required for the Huntingdon County Hospital. The salary is \$80 per month. Board and room provided. Apply to:

Mrs. Irene MacDonald, Matron, Huntingdon County Hospital, Huntingdon, P.Q.

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Provincial Associations of Registered Nurses

ALBERTA

Alberta Association of Registered Nurses

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Registered Nurses Association of British Columbia

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Manitoba Association of Registered Nurses,

Manitoba Association of Registered Nurses.

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Prince Edward Island Registered Nurses Association

Prince Edward Island Registered Nurses Association
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Nursing, Sr. M. Irene, Charlottetown Hospital;
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Registered Nurses Association of the Province of Quebec (Incorporated, 1920)

Quebec (Incorporated, 1920)

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Saskatchewan Registered Nurses Association (Incorporated 1917)

(Incorporated 1917)

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Registered Nurses Association
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A.A., Calgary General Hospital, Calgary
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A.A., Holy Cross Hospital, Calgary

A.A., Holy Cross Hospital, Calgary

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MANITOBA

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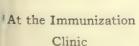
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FATHERS OF CANADIAN MEDIC



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John Gilchrist M.D., J.P., L.M.B.U.C., M.P. (1792-1859)

THE first person to be granted a license to practise "Physic, Surgery and Midwifery" in Upper Canada, Gilchrist walked seventy miles from Cobourg to Toronto to undergo examination by a Medical Board. He was granted his license to practise on the 5th of June, 1819.

He was born on February 5th, 1792, at Bedford, New Hampshire, and was the eldest of four brothers, all of whom practised medicine, and all of whom built similar houses.

In 1822 he was gazetted surgeon to the First Northumberland Regiment of Militia. In 1824 he settled in Otonnabee Township. In those early days it was frequently necessary for doctors to supplement their incomes by other pursuits. Gilchrist found it necessary to conduct a general store and a grist and saw mill.

Gilchrist unsuccessfuly contested a seat for the Legislative Assembly in 1834 and again in 1836. In 1841 he was returned by a considerable majority for the then New Colborne District and, in the following year, was elected Treasurer for the District. He was one of twelve

persons arrested in the Newcastle District for sympathizing with the rebels during the Mackenzie uprising.

He was instrumental in the building of Upper Canada Academy (Methodist) at Cobourg (Victoria College). Later the College was moved to Toronto.

Gilchrist removed to Port Hope where he resided until he died in the month of December, 1859.

His attitude towards the practice of medicine may be best illustrated by his reply to a patient who was unable to pay his medical bill: "When you see a fellow creature in distress, relieve him as far as your abilities will allow; and in so doing you will discharge the debt you owe to John Gilchrist."

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Reader's Guide

The primary function of all nursing service is to provide the essential care for those who are ill. Yet, mental illness, which surely merits as adequate care as any other form of sickness, has been abandoned in many instances to the unskilled ministrations of attendants. To evoke a greater interest in this field, a symposium on mental hygiene and the nursing responsibilities for providing care was featured at the recent convention of the R.N.A.O. With the firm conviction that nurses are willing to assume their rightful responsibility when they are fully prepared to meet the demands made upon them, we recommend these four articles dealing with mental hygiene. Dr. G. H. Stevenson, M.D., F.R. S.C., is professor of psychiatry at the University of Western Ontario and superintendent of the mental hospital in London, Ontario. Mrs. Laura W. Fitzsimmons is nursing consultant to the Committee on Psychiatric Nursing. American Psychiatric Association, New York. Hilda Bennett is on the faculty of the School of Nursing, University of Toronto. Eileen Cryderman is a member of the public health nursing staff of the City Health Department, Toronto, Ontario. Watch for developments in the scheme for the affiliation of student nurses in Ontario.

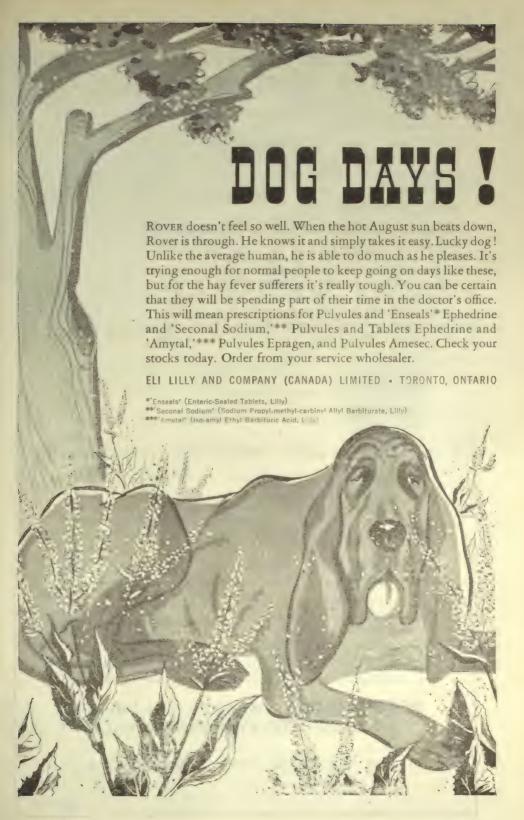
Complementing the discussion of how to deal with children in hospital, we are very pleased to present the informative and interesting article on how to keep the sick child happy, through activity, prepared by Gertrude M. Watts. Miss Watts was occupational therapist at the country branch of the Hospital for Sick Children, Toronto, for several years. She

is now on the teaching staff of that department at the University of Toronto. She is a very gifted person and has always been most successful in devising constructive occupations for hospitalized children, both singly and in groups. Her explicit instructions will be welcomed by nurses and harassed mothers alike.

What factors in the physical set-up of the hospital are of particular concern to the local health department? Aside from giving student nurses an insight into community health services, what contribution has the health department to make to the general welfare of the hospital? Ann Peverley, supervisor in the Westmount Health Department, indicates that there are numerous points of contact where each can assist the other. We are indebted to Miss Peverley, also, for the interesting study on our cover.

When illness forced Atlanta S. Sollows, of Saint John, N.B., to forsake her active nursing career, she found a place for herself in a related service, chiropody. But this is only half the story of her activities. For over two months Miss Sollows spent all her leisure hours making quaint birds with gaily coloured wings and feet, white mice, etc. These were shipped to the organization sponsored by Mrs. J. B. Priestly for distribution to the children of Britain. And, as if this were not enough, Miss Sollows has published a book of poems, and a novel.

Erna E. Hartz is a supervisor at the Saint John General Hospital.



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mum of two years, "there was no evidence of any irritation of the cervix or vagina by the tampon."

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(1) West. J. Surg., Obst. & Gyn., 51:150, 1943. (2) Am. J. Obst. & Gyn., 46:259, 1943. (3) Clin. Med. & Surg., 46:327, 1939. (4) Med Rec., 155:316, 1942.

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1. COLLINS, E. N., PRITCHETT, C. P. and ROSSMILLER, H. R.: The use of Aluminum Hydroxide in the treatment of Peptic Ulcer, J.A.M.C., 116: 109 (Jan. 11) 1941.

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Thus, the testimony of the laboratory and of the controlled clinical investigation has been borne out and strengthened by the test of experience—vast, ever growing, and tending only to extend the range of conditions in which 'Dettol' is applied as the antiseptic of choice.

☆ Garrod, L. P., and Keynes, G. L. (1937). Brit. med. J. 2, 1233

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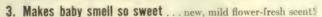
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In Unity There is Strength

There can be little doubt that, behind many of our difficulties in working out more unified national projects, lies the British North America Act. The interpretation of this constitution gives to the nine provinces of Canada wide legislative power, but due to the differences in location, size and natural resources of these same provinces, we observe wide financial variation with resulting inequality of possibilities. A country split into such units, each an entity in itself, is of course democratic, stimulating to provincial enterprise and wholesome rivalry; but with a population of twelve million dispersed in this way, it lacks the cohesive force necessary to national strength and development. Such a background is reflected in every phase of Canadian life. More especially do we recognize this influence in our educational and health services.

Our nursing association is likewise scattered and distributed. Each provincial organization has developed its own constitution, provincial laws and systems. Thus it is that we tend to develop provincially and many activities must, of necessity, be planned according to this arrangement. As we face the impact of



Climo Studios, Saint John MARION MYERS

social changes, especially in health services, it is inevitable that experiments must be tried and new developments studied. If we are to make our best contribution every method toward unity, insofar as our present framework permits, must be utilized. The latest form of activity is Placement Bureaux. In most of the provinces, the initial step in this sudden development was, of course, stimulated through Government Grant funds, together with the need to know our own resources. The National Committee on Placement Bureaux is to be congratulated for suggesting that some sort of co-ordinating influence be brought into these scattered services at once.

The setting up of a diversity of schemes leads to duplication and greater overhead. The National Committee on Nursing School Records has been trying for some time to bring out a set suitable for the whole of Canada. The variety they have encountered shows the need to study our Placement Bureaux records before they, too, become difficult to mould. From the out-look of a small province plunging into this experiment it becomes evident that such a service cannot maintain itself well provincially. Such factors as a small area, limited funds and number of members, even apart from wartime, superimpose limitations.

Nurses, on the whole, move about a very great deal. This characteristic has been even more stimulated through the war years. Interprovincial contacts were made through more post-graduate courses. Many married nurses moved back and forth from Vancouver to Halifax following their husbands. Others, caught by the restlessness of the time, moved anyway, a practice most upsetting to a stable service but, in the long run, producing a consciousness of Canada as a whole and a bond of unity among our scattered people.

In the meantime, as the machinery for better co-ordination gets warmed up, the provincial experiments are having a try-out and we shall doubtless learn much from this sporadic outburst.

In the United States, where Placement Service is older and better established, we observe the trend toward larger units for more effective results. Unity does not come through creating diversity, rather let National leadership and direction give rise to the provincial branch whose reaching out and experimentation is only valuable as it blends into a well co-ordinated national structure.

MARION MYERS
President
New Brunswick Association
of Registered Nurses.

Twilight

Here comes the twilight so silently creeping, Holding the garments of night in her hand; Day has departed with laughter and weeping Flinging its dew to the slumbering land.

. .

There in the western skies tapestries hanging, Arching the mountain tops white with their flame.

God is the artist of that lovely etching Painting voicture that's never the same.

Afar in the woodlands the song thrush is singing

Caroling vespers—how sweet the refrain, From the deep shadows your love strain is

Pervading the twilight with beauty and pain. Grant that life's day so quietly drifting, Slipping through shadows of night to its goal—

May in the twilight see the curtain uplifting—Revealing God's anthem of love to the soul.

E. JAMESON

Calgary General Hospital

The Place of Mental Hygiene and Mental Nursing in this Reconstruction Period

G. H. STEVENSON, M.D.

It is interesting to note changing emphasis in the programs of scientific bodies for their annual meetings. To us in the nursing and medical professions these changes in our own programs are especially noteworthy. This new interest is due not only to an increasing recognition of the importance of this subject but also to a changing concept on the part of psychiatry as to the extent of its field and to the gradually emerging close relationship between physical and mental, a relationship which actually demonstrates that physical and mental are not separate entities, but rather two closely interrelated aspects of health. As doctors and nurses we are now realizing that we are not caring for the physical aspects of disease, but that we are caring for people, endeavouring to keep them in the best possible health, physical and mental. When they become ill we think primarily of them as sick persons, sick perhaps both mentally and physically, whom it is our joint responsibility to bring back to good health.

This union of the mental and physical aspects of health has resulted in a new concept of medicine, now known as psychosomatic medicine. This word need not alarm anyone as it is only the Greek roots of mind and body, the psyche and the soma, and please note there is not even a hyphen between the two parts of this word, indicating again the indivisibility of health, but indicating nevertheless that health has at least these two aspects.

I do not propose to discuss this concept at any length, but do desire to indicate that much physical disease has a mental element, that disturbed emotions can and do influence such somatic expressions as peptic ulcer, hypertension, cardiac symptoms, insomnia, fatigue, skin conditions, metabolism, allergic conditions; that the individual's attitude to his disease may greatly influence its severity and its outcome; that people may be made delirious by disturbed emotions: that many emotional disturbances can and do produce a great variety of physical symptoms, as seen so commonly in the war neuroses; that emotional disturbances are often the result of environmental difficulties and adjustment problems with which the public health nurse is constantly confronted and challenged to do something. Conversely, purely physical diseases lower our mental health, decrease our efficiency and feeling of well-being, produce emotional instability and conduct disorders, and when emotions are made unhealthy, by physical illness or any other cause, we may not think clearly and logically, may even develop delusions.

This brief summary indicates something of the remarkable transition of psychiatry from its former narrow field of the psychoses as seen in mental hospitals, unrecognized by physicians and nurses alike, as cases of illness coming within their sphere of professional interest, to its present integration with general medicine and its increasing centralization in the general hospital. It indicates also why the medical and the nursing student are no longer welltrained for their respective tasks unless they are thoroughly conversant with the psychological factors in disease and the relationship of the environment as a whole to health as a whole, that is, public health or social medicine.

This does not mean that psychiatry is no longer interested in the psychoses. This large group, occupying as many hospital beds as all other sick people combined, is a constant challenge to our

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respective professions. I prefer to use the word delirious to psychotic as, in my opinion, these two names are equivalents, and because we cannot refuse responsibility for delirious patients. Our mental hospitals are hospitals for the care and treatment of delirious persons. These delirious states may be due to physical or mental etiology, or a combination of the two. They may be of short or long duration, but they are definitely our joint responsibility. This means that the nursing of the patients in these hospitals, not only the physical nursing but all the nursing of both women and men alike, should be directed by a qualified director of nursing, and that every ward should be directed and supervised by a broadly trained registered nurse, assisted by other registered nurses and subsidiary non-professional staff. Nor should such nursing be necessarily limited to women nurses. The nursing profession should train male nurses for, in the nursing care of delirious persons, registered men nurses should be a valuable group.

In the general hospital we find an increasing tendency to have a psychiatric ward or service. Certainly every general hospital should have a unit for the diagnosis, proper treatment and nursing care of delirious patients. Such units should be for short intensive therapy and only the more severe or protracted delirious patients should be sent on to the provincial mental hospital. In every general hospital there will also be non-delirfous mental conditions, the neurosis and mental complications of physical diseases. The nurse has her part not only in the use of the modern "shock" therapies, hydrotherapeutic techniques, some occupational and physiotherapeutic assistance but also in the psychotherapeutic approach. She has a right to know the full nature of the patient and his illness, so far as the doctor may be aware of it, and should expect to collaborate with him in everything that may be for the patient's welfare.

Psychotherapy is a broad and perhaps rather vague term to many of us. Ac-

A. S. S. S. 1. tually it means the attempts we make to influence favourably the psychic aspects of the patient's health by the direct or indirect use of mental elements in our own personalities. Direct psychotherapy might involve an analysis of the patient's life experiences, his mode of thinking, his reactions to his environment. It might call for hypnotic or narco-hypnotic treatment and analysis, as has been used so much in war neuroses. It might entail strong positive suggestions to the patient; it might involve re-education of the personality, encourage better sublimations and healthier escape mechanisms. Indirectly, the personality might need to be built up by the strengthening of the somatic features by appropriate medication, diet, exercise, etc. The whole attitude of the doctor and the nurse to the patient is important, their success in encouraging his will to be well, the degree to which by their tact they secure his co-operation, the example they show the patient in their own attitudes to life and its problems. All these are psychotherapeutic considerations. The division of psychotherapeutic responsibility between the doctor and the nurse should be well understood in the same way that the surgeon and the surgical nurse divide their responsibilities. Only the surgeon makes the diagnosis, only the surgeon makes the incision. The nurse makes the preparation, she assists him with the operation, she is largely responsible for the after-care. Similarly in psychotherapy the physician will have to assess the factors and make the diagnostic evaluation. He may have to cut into the depths of the patient's consciousness, at times painfully; he will have to develop the therapeutic program. The nurse's part will be that of full co-operation with the doctor, being careful not to work at cross purposes with him, to go no further with the probing or dressing of mental wounds than the doctor instructs, to protect the patient's personality from unnecessary injury in either its psychic or somatic aspects; she develops the patient's confidence in his

ability to recover and in the treatment program; she takes part in the re-educational and sublimative features; she emanates optimism and encouragement; she shows a healthy personality reaction to her own life and her job. This brief survey of psychotherapy does not attempt anything more than an indication of its importance, additional features of which should be included in every nurse education curriculum.

Psychosomatic medicine has an increasing importance in the out-patient department of general hospitals, in children's hospitals, in buterculosis hospitals, in hospitals for chronic diseases, in hospitals for the aged and in home nursing. Hospitals for the care of the aged (geriatrics), a counterpart to hospitals for the care of children (pediatrics), are urgently needed. With the old age group, a constantly increasing group, having a high incidence of mental enfeeblement as well as physical degeneration, such hospitals serving geographical areas will be found to fill a real need, will prevent the overcrowding of mental hospitals, and will provide a broad field for nursing skills.

Mental hygiene, preventive psychiatry, is a part of the broad field of preventive medicine in which both doctors and nurses have a part. Preventive psychiatry involves the right to be wellborn, to have intelligent, well-adjusted parents, capable of giving good health training to the young; it involves good housing, a balanced and sufficient diet, good habit formation, well-conducted schools (and well-conducted teachers), decent economic opportunities and good international relations. Obviously the doctor and nurse cannot be responsible for all of these things but it is certainly our duty to know the various factors which influence mental health and to give leadership in the movement for good health in its physical and mental aspects.

In the prevention of mental disorders and the preservation of good mental health the public health nurse holds a key position. The first rule for keeping mentally fit is to keep physically fit, so that whatever the public health nurse does for physical fitness and the avoidance of communicable disease, in decent housing, and decent food must make for better mental health. Better prenatal, obstetrical and post-natal care contribute to this end. The public health nurse is in a position to appraise other factors in the home which may have an influence on mental health - economic security, domestic happiness, good ethical standards, emotional stability, affection, example set — if these be good the effect will be good, if they be poor, the effect is likely to be adverse. Broken homes, foster parents, invalidism, dependence, anti-social behaviour - all these may have significant influences on growing children and need to be handled with care.

The mental health clinic has been a development of recent years and has served a very useful purpose in assisting physicians, parents and the schools with early or incipient mental disorders or behaviour problems of an unhealthy nature. In Ontario there have been travelling clinics covering every part of the province, although not as extensively as could be desired. In order to enlarge and improve this service the Department of Health plans additional clinics as soon as trained staff are available. Ultimately these clinics will be divorced from the mental hospital and will become a part of the services of the municipal health unit, along with other clinics, dental services, etc.

The personnel of such clinics has usually consisted of a physician, a social worker, a psychologist and a secretary. You will note that a nurse is not a member of this group, in spite of the fact that it deals with the health of people in its largest aspects. The reason for this omission lies in the historical development of the mental health clinic, having its origin in the United States in connection with state mental hospitals. These hospitals have had relatively few

registered nurses as members of their staffs, most of the actual care of the delirious patients having devolved upon non-professional personnel. The comparative lack of interest of the nursing profession in severe mental illness and their employment in such small numbers made them a relatively unimportant group in the psychiatric set-up. Parallel with this nursing indifference there was a marked growth of interest among social workers in the problems relating to the environment as contributing to mental illness, a movement which led to the development of a specially trained group known as psychiatric social workers. These persons are primarily social workers who have taken additional training in psychiatric factors. We adopted the United States type of clinic personnel, even though few of our social workers had had previous psychiatric experience. The social worker without psychiatric nursing experience is undoubtedly handicapped in such work. The registered nurse, psychiatrically trained but lacking in certain aspects of social work, would be similarly handicapped in this important preventive field.

I am not at all sure that the nursing profession wishes to undertake this additional field of responsibility but it is a field to be greatly enlarged and it is definitely in the field of preventive medicine. I would recommend it to your serious consideration. The mental health clinic may be one of the most remarkable achievements in the post-war period. In the same way that every contact with a case of active tuberculosis is examined by a tuberculosis clinic so every child and adult in contact with a frankly mentally ill person should be examined by a mental health clinic. Mental illnesses, like tuberculosis, are always due to exposure to adverse influences and that old superstition, defective inheritance, need be no more regarded than it is in tuberculosis. It is probable that Boards of Education, at least in the larger centres, will in time develop their own guidance clinics for school children. The public health nurse, in the role of the school nurse, working with the doctor, the teacher, the psychologist and the parent, will be an important and constructive member of such an organization.

In the field of family care of mentally ill patients and in the care of patients returned to their homes from mental hospital there is no question that these functions belong to the nurse rather than the social worker. It should be realized that the fruit of the mental hospital is to be found in the number of patients it is able to return to the community. The importance, therefore, of keeping these people well in their homes and of returning them to employability, or at least good social adjustment, cannot be overstressed and should be a nursing responsibility. It is both home nursing and public health nursing to a marked degree and should be adequately staffed. There is little gain if we spend weeks and months aiding a person back to good mental health unless we do our best to provide an environment in which that personality can thrive.

In summing up, therefore, I would emphasize the responsibility of the medical and nursing professions for all people in their health relationships, keeping them well and restoring them to health when ill. I would stress the concept of health as a psychosomatic unity, not divided into physical and mental. Sick people have to be nursed in their homes and in hospitals of all types and most sicknesses have a psychological element, small in some predominantly physical ailments, large in others and in the deliria seen in mental hospitals. In the broad field of preservation of mental health, an attempt has been made to indicate the role of the nurse in public health, in the mental health clinic, in the school, in the out-patient department. The nurse, in addition to being a welltrained bedside nurse, needs training in public health, in social medicine, in mental hygiene principles and psychotherapy.

Mental Hygiene and Hospital Nursing

LAURA W. FITZSIMMONS

That mental hygiene should be a part of all nursing is a fact too elementary to need mentioning, yet, strange as it may seem, all too often mental hygiene has been more conspicuous by its absence than by its presence in the curriculum of the student nurse.

There are several angles from which I should like to approach this subject first, as to guidance or the practice of mental hygiene in relation to adjustment of the nurse herself. I am happy to say that in recent years we have made progress at least to the extent of recognizing that there is a place for mental hygiene and guidance in the development of the nurse, but we in the United States are far from an achievement of this goal. Almost ten years ago the League of Nursing Education published the Curriculum Guide for schools of nursing which had for its central theme "The Adjustment Aim", but we have continued to subject the young woman who comes into a school of nursing to a pattern of discipline and repression which is not conducive to self-development and those who emerge as individuals do it in spite of, and not because of our educational system. For instance, many of the young women who enter our schools of nursing, and especially those who have enrolled during wartime, have been to college or have been earning a living with full responsibility for themselves. As student nurses they are directed for practically every minute of the twenty-four hour day, and subjected to discipline in most instances if they fail to transform quickly from individual to automaton and to conform consistently to a stereotyped pattern. After this crippling process of approximately three years, we expect the nurse to assume full responsibility for herself and for others. It seems to me that we have here a whole field for

the application of mental hygiene in the form of guidance which will stimulate and direct the young women who come into our schools of nursing. Do not misunderstand me and believe that I am advocating a lack of moral training or responsibility. On the contrary, I believe that we would have a higher degree of total development with fewer eliminations from the student body if we set about to study ways and means of aiding the development of the students by understanding their problems and encouraging their special talents, rather than disregarding the concept of individual differences, attempting to pour them all into the same mould inwardly even as we have patterned their uniforms outwardly. This has been very forcibly brought to our attention in regard to the apparent necessity for drafting nurses into the army. Over and over one heard the remark made, "Why didn't they tell us what to do?" or "We were just waiting to be told what we should do" or "Now I shall go in. I was just undecided". So great has been the response to President Roosevelt's message that an actual draft may not be needed. But the point is that our lack of the practice of good mental hygiene has tended to atrophy in the nurse the most prized of all human possessions, that of individuality, and the freedom that comes from reasoned choices. An entire paper could be written upon this subject but I shall pass on to other angles of this topic.

Proceeding more directly to the hospital situation—for years we have talked of well-rounded programs of education for student nurses, yet with more beds in the United States occupied by mental patients than by all others combined we have fourteen states that give no courses whatsoever in psychiatric

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nursing (January, 1944, survey) although everyone of those states have schools of nursing. What does this mean? Briefly this, that while money has been spent lavishly to recruit student nurses and to prepare them, many of our mentally ill are being cared for by people untrained in psychiatric nursing. Because so many of our nurses were untrained in the care of mental patients, the army has had to establish courses in psychiatric nursing. It is indeed a shocking situation when graduate professional nurses, who are taken into the army as commissioned officers, must return to the status of students and the army, under the burden of war, be forced to complete the necessary education for these nurses before they can adequately meet the army's present needs. This should make us hide our faces in shame at the job we have done or rather failed to do. Until every nurse is prepared to care for mental cases, we will not have learned the lesson of this mistake.

With regard to the thirty-four states giving courses in psychiatric nursing these range from an elective course taken by a few students to a specified course as pre-requisite to registration. At this time three states and the District of Columbia require this in the basic program before the nurse can obtain her license to practice. The most prevalent type of course is the affiliation ranging from eight weeks to sixteen weeks, the trend being toward the shorter periods following the compression of the entire course of study under the United States Cadet Nurse Corps plan. There are also basic courses where the nurse receives two years of her education in the mental hopsital and one year in the general hospital. These, however, are very few, being actually only thirty-two out of a total of 1,307 accredited schools of nursing in the United States. There are also senior cadet programs in psychiatric nursing. Under wartime planning, the formal class work has been placed in the first thirty-month period of the threeyear program leaving the last six months for optional work by the student where she really functions as a relief for the graduate nurse. During this period many of the students choose a mental hospital, thus adding this experience if it has not been given or supplementing, in some instances, a short affiliation.

Dr. Pratt* has said that (in the United States) already more than three hundred thousand men have been discharged for psychiatric conditions and about thirty thousand more are being discharged each month. This does not take into consideration the acceleration in mental illness among the civilian population as a result of the broken homes and other maladjustments associated with global war.

What are we going to do to stem the tide? How will we, as nurse educators, meet the problem? What provisions are we making for the future or even to care for the more than half million mental patients that are presently with us? Call these post-war plans, or planning for the future, or what you will. Briefly, what we, who are concerned with psychiatric nursing, propose is this: First, to encourage and strengthen the basic schools in every possible way. Second, to use the psychiatric hospitals for affiliate courses for students in the general school of nursing to the extent that this will become a part of the education of every nurse. While it is conceded that a few weeks or months spent as an undergraduate student does not make a clinical specialist in psychiatric nursing this should be a valuable experience to the nurse in many ways. It should give her a better understanding of all of her patients, and thus contribute immeasurably to her efficiency in the general hospital. No hospital and no field of nursing is without its psychiatric problems whether they be so labelled or not. Mind and body are not separate entities, but parts of a whole and one cannot be considered except in relation to the other.

^{*}Pratt, George K., M.D., "Soldier to Civilian — Problems of Readjustment". Whittlesey House, New York, 1944. p. 15.

We have come a long way during the last twenty-five years in establishing this concept. Only a few years ago mental illness was considered hopeless and custodial care was the accepted treatment. We have seen that picture change. Now many of the large medical treatment and research centres have their psychopathic departments even as they have pediatrics, obstetrics and others. Psychosomatic medicine is so permeating the picture that the nurse and physician of the future cannot afford not to have this preparation. You will be interested to learn that one of our universities having a psychopathic department also has a number of beds on halls in the general hospital where patients are being treated by physicians of the department of psychiatry, without being transferred to the psychopathic unit. These are, of course, selected cases but it is a novel procedure, and merits mention as a trend. That psychiatry for all nurses is not impossible of achievement has been demonstrated by the fact that it is being required already by three states and the District of Columbia. If by these, why not by all? Such a program would give an introduction to psychiatry and undoubtedly many nurses, after graduation, would seek this as a field for further endeavour. Under the present system, many of our nurses graduated every year have never been inside of a mental hospital and, therefore, are often as apprehensive and fearful as a lay person when in contact with a case of frank mental disorder. A further significant contribution from such a program should be that of developing the personality of the nurse herself. Any course in psychiatric nursing which does not make the nurse more tolerant, more tactful, more observant and withal better able to adjust to life situations has failed in its purpose.

The chief handicap to the realization of this goal of study is a lack of competent leaders to establish and direct such courses. Knowing that the supply has never been adequate, little relief can be expected with the cessation of hostilities and consequent return of nurses to civilian life. We believe that the approach to this will have to be made through the establishment of post-graduate courses. In 1942 and 1943, postgraduate courses had practically ceased to exist. In hospitals visited in the United States during those two years, there has been recorded a total of only four graduate students enrolled. Naturally young nurses are not going to take time for this when they are so greatly needed for immediate service. However, the colleges and universities do not report such drastic curtailment in enrolment. Therefore, in order to attract students and raise the level of psychiatric nursing education, it was thought desirable to work out co-operative arrangements between some of the universities with established curricula in nursing and certain of the better psychiatric hospitals. This, it was thought, would lead to post-graduate courses of a higher caliber and consequently, more satisfactory than many given heretofore.

It is a fact that by far the larger number of the so-called post-graduate courses were in reality prolonged bedside courses at an undergraduate level. True the nurse had graduated, but often it was her first introduction to psychiatric nursing. Frequently, the lectures for graduate and student nurses were combined. As a consequence, the post-graduate course became merely an extension of the basic preparation. The graduate student, who came to the course with previous psychiatric nursing experience, often was disappointed with her program because she received little more than ner sister who had a basic affiliate course. While bedside courses have much to recommend them, they do not prepare the leaders in psychiatric nursing so urgently needed at this time.

Hospitals are primarily service institutions and few have the educational staffs for advanced teaching. Universities, on the other hand, serve this particular purpose. Does it not seem reasonable, therefore, to combine the two?

With this in mind, plans for such courses were evolved and eight have already been established. The first of these was between the Catholic University of America and St. Elizabeth's Hospital, a mental institution of over seven thousand beds in Washington, D.C., and the second was at the University of Minnesota and the Rochester State Hospital. During the survey period of my work the best course for graduate students that I came upon anywhere was that given in Ontario. It furnished much of the inspiration and pattern for the courses which we have subsequently established. An article which appeared in the December, 1944, issue of the American Journal of Nursing gave the details of this program as to its organization and curriculum content.

This discussion has centred around the registered nurse or the student who expected to become a registered nurse. You are, of course, familiar with the concept of nurse education fostered by Miss Nightingale, who, wise woman that she was, advocated the preparation of two types or groups of nurses. Those less well-qualified prior to training were entered as probationers; the better educated who were the potential leaders were called the lady probationers. The schools of nursing lost this concept early and the whole drive has been to have only graduate nurses prepared and those upon the basis of higher and higher standards. This has worked many hardships upon the hospitals, the patients and the nurses. Until the United States Cadet Nurse Corps came into existence, as an emergency measure, our plan of education of a nurse was expensive to

her which in turn made her service costly and reduced the number of nurses in direct proportion to the elevation of the standards for admission. Yet, no provision was made by the nursing profession to prepare others at a lower level for the less specialized duties not requiring the high degree of intelligence and skill as those performed by the professional nurse. With the large numbers of patients in mental hospitals, few psychiatric nurses, and with budgets often too low to employ those that might have been available, the mental institutions have depended to a great extent upon attendants for nursing care. There have been no courses developed for this group except by the individual hospitals, and in a few instances by the State Departments of Mental Hygiene as an over-all syllabus. Lacking a standard curriculum, the range has been from no instruction to courses out of all proportion to the status of the position or the duties to be performed. Such a system is time-consuming, economically wasteful and leads to a variety of techniques. Plans are now being made for recognized courses for attendants and practical nurses. Fifteen states now issue a license to practical or vocational nurses as they are often called.

In summary, the major trends in psychiatric nursing are as follows:

1. To include psychiatry in the program of every student nurse.

2. To establish post-graduate courses which will be truly what the term implies, courses at the graduate level.

3. To establish relatively uniform courses for attendants and practical nurses on the basis of a curriculum.

Preview

During the past five years there has been an astounding increase in the number of nurses engaged in industrial health services throughout Canada. The Committee on Industrial Medicine of the Canadian Medical Association has adopted for use here the "Standing Orders for Nurses in Industry" formulated by the Industrial Health Council of the American Medical Association. In order that all Canadian nurses may have ready access to these standing orders, they are to be included in the August issue of the Journal.

Occupations for the Sick Child

GERTRUDE M. WATTS

Occupations for sick children may be divided into two groups: those planned as specific treatment, when occupational therapy has been prescribed, and those given in response to the plea of the convalescent child "What can I do now?" The nurse is often the one to whom the plea is made. The following activities are suggested to create a happy atmosphere for your patients, to make them more content and co-operative and thus help to maintain treatment.

Most children have a great deal of energy, and after the acute stage of illness this desire for activity should be directed into constructive channels. Children in bed have little outlet for their energies, especially when treatment necessitates immobility or limitation of movement. If no opportunity is given for constructive occupation, frequently destructive behaviour is the result. Many occupations can be adapted, with a little ingenuity, for the child in bed.

Before he goes to school the child learns by investigating the objects about him, and imitating the actions of the people in his home. If a patient's convalescence will be long we should see that he does not miss the everyday things which he would normally learn if his environment were not limited. In his daily occupations the child of preschool age should be gradually absorbing knowledge of colour, shape, size and proportion. He should learn how to play with toys, colour with crayons, cut with scissors, and to count. These are all things which he will be expected to know when he goes to school. His activities should be as nearly like those of a well child as his illness will permit.

In hospital occupations may be individual or group activities depending on the circumstances and the hospital set-up. Sick children tend to individual play in contrast to well children who tend to play in groups. Where possible it is advisable to include the sick child in group projects or in group games. It makes him less self-centred, and adds to his interests and happiness, for children are sociable little people and like other children. Unless they are given some guidance and help from the adults who are caring for them, group play is difficult. Frequently the occupation must be individual as there is a wide difference in the requirements of the patients.

EIGHTEEN MONTHS TO FOUR YEARS

From the age of eighteen months to four years we find that occupations do not differ very much for boys and girls. At this age the span of attention is short, and the child should not be given a large and bewildering collection of toys at one time. The easy way is to make up his bed, give him all his toys, and expect him to be happy and amuse him-



Listening for the "click".

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self. Usually he tires of them all in a few minutes and begins the fascinating game of throwing them over the side of his crib. It is better to give him one or two playthings for half an hour then, if he seems to be getting bored with them, remove them, allow time for a short rest and provide him with a new toy for the next hour. This method requires planning but it is well worth it. Small children enjoy the same toy each day for a surprising number of days if they do not have it long enough each day to tire of it. Some little thing about it can be changed to make it seem new and interesting.

Toys for the tiny child may include:

- 1. A bright balloon tied to the side of the crib. If the patient is lying down it can be suspended from a cord stretched taut from one side of the crib to the other side.
- 2. Spools painted bright colours and arranged on a strong cord in the same way. These may be varied by painting the spools like a train and showing the baby how to make it go across his bed on the cord as if it were going over a bridge. Another variation can be made by substituting for the spools blocks that have pictures on them (especially pictures in relief that the child can feel) or small animals, little bells, boats, tiny dolls or toy soldiers. If the cord is fastened so that it is taut and secure, it is difficult for the patient to put the toys in his mouth and they do not slip out of his reach and fall on the floor. The articles may have holes drilled through them or be fastened by loops of string so that they will move back and forth on the suspended cord.
 - 3. A Noah's ark with the animals. It may



Using the spinal mirror.

be varied by removing the ark and replacing it by a barn, a house, trees and fences so that it can be used as a farm.

- 4. Blocks. There are many different kinds. The "Hi-Lo" blocks, with raised ridges on the sides so that one block fits into another block, are easy to handle. Nests of blocks are popular since they can also be used as little boxes.
 - 5. A sea shell that sings a song like the sea.
- 6. A colour cone consisting of a base with an upright peg and several disks of different colour and size. A hole in the centre of each disk makes it possible to slip the disk over the peg.

All children of this age enjoy toys which involve fitting objects into a container, removing them, and replacing them. Of this kind are peg boards, large and small, with coloured pegs, simple puzzles, and beads and spools for stringing. To make it easy for the beginner to thread beads the end of the lace may be stiffened by dipping it into shellac.

If it is difficult to obtain equipment, a little ingenuity can readily make substitutes. Dowelling can be cut into lengths and painted for pegs. The peg board can be made from scrap wood with holes bored in it. Spools or large buttons will serve as beads. Many little children will be quite happy dropping large beads into a cardboard tube, made from the roll in which calendars are mailed. One end is closed by sticking cotton over it and the roll is painted a bright colour. The child is given twelve or fifteen beads, the tube, and a box, and shown how to fill it up with beads, then dump them out in the box. The beads make a delightful "click" as they fall on each other in the cylinder and a grand noise as they are dumped out again — very satisfying to a two-yearold in bed.

A bed table of the right height will make your patient more comfortable as he plays. If one is not available, one of the heavy cardboards which come with x-ray films will make a satisfactory substitute.

Some children are imaginative in their play and will always be able to happily occupy themselves. It is the ones who do not know how to play, and who, given equipment, do not know how to use it, who will need your help. After you have made some suggestions and have played with the unimaginative child for a few moments, go away and leave him to carry out your suggestions by himself, or with the child in the next bed. Resist the temptation to do the child's playing for him, with him in the role of onlooker. He needs practice in playing as in all the other things he is learning.

FOUR TO SIX YEARS

For four and five-year-olds, colouring with crayons, cutting with scissors and other forms of paper work which are simplified kindergarten activities, are useful. Colouring should be simple and may progress by the following steps:

- 1. To become accustomed to holding and controlling the crayon the child can make random marks on paper kept from old Christmas cards. Never leave a small child with crayons, without paper. It takes him only a few minutes to find that the bedspread or the wall will do.
- 2. Draw simple pencil outlines of balloons, kites, apples or boats. Show the child how to colour the area inside the outline.
- 3. After a little practice the patient may be given pages from colouring books in which the pictures have large simple outlines with little detail.

Learning to cut with scissors should also progress in graded steps and, here again, the little girl will not be tempted to cut her hair if you see that she has something more interesting to cut when she has the scissors:

1. Show her how to hold the blunt scissors, and how to open and close them. Some children find this quite difficult. She will



Completely absorbed

be awkward at first but will soon get the "feel" of the action.

- 2. Have her make random cuts on scrap paper until she learns how to control the scissors. This is a good time to teach that it is more fun to cut the scraps into a box than to let them fall all over the bed or the floor.
- 3. Across an oblong of scrap paper draw a line about one half inch from each end, and show her how to cut a fringe, the cuts going in as far as the pencil line from each end. When finished she has a little 'mat which may be decorated with crayons and used in a doll's house.
- 4. She will now probably be ready to do straight line cutting, then advance to cutting out objects, and finally will enjoy cutting a paper doll and her clothes.

After small children learn to cut and colour they can progress easily to all forms of paper work which include drawing, cutting and pasting. Directions for paper parquetry and paper construction are available in many books and may include pictures to illustrate stories that have been read aloud, Valentines, Hallowe'en Christmas cards, Christmas decorations, and numerous other subjects. Paper chains are always popular. There are two kinds. The simplest is made by threading alternately on a string, pieces of coloured paper with a hole punched in the centre, and one-inch lengths of drinking straws. A

blunt needle is used. The other kind you will remember making in kindergarten. It consists of about thirty pieces of coloured paper, each piece measuring six inches by one half inch. The ends of the first piece are overlapped and pasted so that a circle is formed. The next piece is slipped through the circle, then pasted to form the second link, and so on until the chain is complete.

Painting may be introduced to young children by means of paint with water books. These books have the colour printed in the picture and require only a moistened brush. It is more satisfactory to give the child in bed one picture at a time rather than the whole book, as it is easier to handle. Clip clothespegs can be used to fasten his paper in place if he can use only one hand.

Small cotton picture books, made by pasting pictures on pages cut from crinoline, then stitching them down the centre, are practical. They should not exceed six by seven inches when finished, to be easy to handle in bed.

The tiniest children like nursery rhymes. When they have learned the words, they enjoy them more if you say part of the line, then wait for them to guess the terminal word. For example:

You: Little Jack Horner sat in a -

Children: corner!

You: Eating his Christmas -

Children: PIE!

Nursery rhymes set to music, and songs with actions, are fun. If you cannot sing, a portable phonograph will help you, and it can be used in many different ways. Records of lullabies, and of nursery songs with appropriate sound effects, make good listening records, while music with a marked rhythm to which the children can keep time by clapping their hands is a good choice to alternate with the others. Robert Louis Stevenson's poems set to music—"My bed is a boat" and "The land of counterpane" have a direct appeal for children in bed.

Stories, particularly the well-known and well-loved stories such as "The Three Bears," "The Old Woman and her Pig", "Peter Rabbit" and "Little Black Sambo", have an important part in a sick child's life. Choose a version that is well expressed, and always tell or read your story in the same words. Little children like to hear the same tale over and over again, but they like it told the same way, and you dare not change a word or there are protests.

SCHOOL-AGE CHILDREN

When a child goes to school, he acquires skills and ideas which enable him to provide himself with individual occupations more readily than can the younger child who has not had this advantage. Therefore the adult looking for occupations for older children who are ill finds that the group activities are those which require more planning and direction by her. These may consist of games, music, stories, and group craft projects.

A group of children usually shows a happier and more spontaneous response to games than to any other form of activity. If the difference in age is not too great, the game may be one of skill. If the age spread is wide, the game should be one which depends on chance, otherwise the older children always win. For two players there are such games as checkers, Chinese checkers, dominoes, parchesi, and many progressive paper games. Games for a group of six or more must be planned, and sometimes constructed, too. They are more satisfactory if they can be conducted by someone who is free to move from bed to bed, taking equipment from one player to the next player. Here are some examples:

Clothespeg game: This requires a substantial cardboard box, and a spinner, of the kind often used in games, with V-shaped wedges of colours. The round knobs at the

top of several clothespegs are painted in the same colours three of each colour. Each player is given three pegs of one colour. The spinner and the box are carried from player to player, who each spin in turn. If the arrow stops at the same colour as that on the player's pegs, he may put one peg on the box—for example — the child with red pegs must spin red to put a peg on the box. The first player to get his three pegs on the box wins the game.

Horse racing game: Each player is given a cardboard with coloured squares which represents a race track. He also has a small toy horse. The person conducting the game goes from bed to bed to each player, carrying a small box containing several blocks with numbers on the wrong side. The players draw in turn. If a player draws a block marked three his horse advances three squares. The player whose horse reaches the end of the track first, wins the game.

Match-it: Picture cards whose two halves match to form a picture are shuffled and dealt. If possible each player should have an equal number. A selected player begins by holding up a card and saying, "Who has half a dog?" or whatever the picture is. The player with the other half calls "Match-it" and the card is carried to its new owner, who in turn calls out one of his unmatched pictures. The player to match all his cards first wins the game.

Bingo and Picture Bingo are also useful games for a group of patients in a ward.

Some older children are fond of music, and this interest can be fostered by teaching songs and Christmas carols, and by the use of phonograph records on which the artist whistles, for the children like to whistle too. A rhythm band can be used with music which has a marked rhythm, such as marches and waltzes, each child playing an instrument. Select the records that have something very definite for which the boys and girls can listen. Walt Disney's Snow White, Dumbo, and Pinocchio are popular. Short explanations should precede the playing of The March of the Toys, Saint-Saens' Carnival of Animals, and the symphonic story of Peter and the Wolf. Music can be provided for all tastes, but it is important to buy the best recordings, by the best artists. Surprisingly often, children comment on the quality of the performance, and our choice may be helping to form their standards.

OLDER CHILDREN

The bed occupations of older children should be planned, so that there is a balance between those we might call constructive, and those which are merely entertaining. Children on surgical wards are usually mentally alert, but those on medical wards often become sluggish mentally. If the child is ill a long time, his occupations should progress in difficulty. He should first be given something that he can do easily, which gives him a feeling of success. Later the intricacy of his work can be gradually increased. In this way we can avoid the fatigue and frustration which goes with failure and the inevitable cry "I can't do it, give me something else", which is the beginning of poor work habits. Many boys learn, by playing with Meccano sets, the rudiments of handling skilfully small screws and nuts and parts of machines.

Woodwork is the favourite occupa-



Reed work.

tion of older boys. Balsa wood, being soft and easy to cut, is good for a beginner to use, and later he can work with basswood or white pine. Some bed patients can use a coping saw if the cutting does not take too long. Many small objects, such as model aeroplanes, boats, trains, paper knives, garden stakes, painted in colour to mark the location of the tomatoes and carrots, totem poles, and door stops are easily made in bed. Older boys also enjoy drawing and painting. Attractive posters can be made to brighten the walls of the wards.

Basketry and caning are interesting, but their use is limited because the material requires soaking in water. Soap carving is a clean, quiet craft which appeals to both boys and girls.

Older girls usually enjoy needlework, which has a wide scope. The patient herself should do as much as possible in preparing, working and finishing the project. Generally it is more interesting if it is fairly short, if it is something to wear, and if it has bright colours to make it attractive. Once a mother was heard to remark that she was going to start her daughter, a post-poliomyelitis patient, eleven years old, on a quilt, because it would keep her busy for a long time. The girl was not interested in plain sewing and quilts did not appeal to her. A long project of this kind, in addition to becoming very tedious, would be difficult for her to handle and quite

impossible for her to finish. We persuaded the mother to give her a more suitable project — a lapel ornament or purse made of felt, or some dainty embroidery.

Girls enjoy sorting and stringing beads. Many like to do leather work, knotting, and weaving. The girls of eight, nine, and ten years love to play with dolls, and dolls' trunks full of clothes, baking sets and dishes, toy cardboard villages, and mosaic beads. Magic dolls, which have a suede-like finish, and clothes made of flannel, are useful for the small girl in bed who has difficulty in handling paper dolls. The clothes stick on the doll easily.

Painting and drawing are usually popular. Older girls enjoy crayon drawing on cotton. The design on a laundry bag or apron is applied with wax crayons. It is then pressed on the wrong side using a damp cloth and hot iron. This pressing sets the design and makes it washable.

These suggestions are intended as a foundation on which the adult who is interested may build. Children today have little leisure time, and the occupations used during a long convalescence may be the means of introducing the child to new and hitherto undiscovered interests. In addition to keeping him temporarily content, they may develop abilities and skills and broaden his horizons, thus contributing to his future happiness.

The Hospital and the Health Department

ANN PEVERLEY

Every community requires the specialized services of both hospital and health department. It is, therefore, reasonable that consideration be given to some of the relationships existing between

these two bodies. It is also timely, since increased emphasis is being placed on the integration of health and social aspects of nursing in the basic course of training for student nurses.



Associated Screen News, Montreal The school girls are interested in health.

From the hospital point of view, the patient comes first. Therefore, a healthful environment and sanitary procedures as they relate to the patient, either directly or indirectly, are very important. These matters are of equal concern to the hospital and the health department, and all resources of the health department are at the disposal of the hospital administrator. Health practices are possible when the administrative authorities within the hospital have recognized the significance of this aspect of the patient's care. Then follows organization and the intelligent co-operation of all concerned. These factors include:

Adequate accommodation and proper ventilation. The health department has definite regulations governing these conditions and is able to help solve problems relating thereto.

Care of milk and other foods. Good house-keeping methods are extremely helpful. We recognize the fact that certain types of foods provide excellent media for the growth of bacteria. We know that a constant temperature should be maintained in refrigerators, and that attention should be given to overcrowding and ventilation as well as to regular defrosting and soap and water cleaning.

Ice. It is essential to avoid contamination of chipped ice served to patients. This in-

volves proper storing on racks, small trucks to convey the ice, and the washing of the ice before it is crushed. It is necessary that the crushing machine and pails be sterilized daily by the use of a chlorine compound.

Dish washing. This is a very important part of hospital housekeeping and one which frequently requires the advice of the health department's trained sanitary inspector. We are accustomed to exercising precautions in the adequate care of dishes used by persons known to have a communicable disease, but we sometimes overlook the menace to patients not known to have a communicable disease, and to the staff when any institutional dishes are improperly washed. This contributes greatly to the spread of communicable disease. It is agreed that cracked dishes and worn, misshapen forks should be discarded.

Use of detergents. The person in the hospital responsible for purchasing such items could profitably consult the health department so that a wise selection might be made.

The cleansing and sterilization of baby's bottles and utensils used in the preparation of feedings, as well as care following sterilization. This constitutes a procedure in which the health department is most definitely concerned as well as with the method of transferring milk from bulk to bottle.

Cleanliness, adequacy and location of utility-rooms and isolation bathrooms. Problems arising through various circumstances may be successfully solved through the joint

efforts of health department and hospital.

Isolation technique and terminal disinfection. This is of interest to the health department because of its policy regarding the prevention and control of communicable diseases. Basic to these procedures is a knowledge of the health department's regulations as well as the technique taught by the hospital.

Cupboards. Any woman who has kept house appreciates the significance of cupboards. All cleaning materials and insecticides can be safely kept in suitable cupboards if properly labelled. The health department is anxious to reduce the accident hazard as well as interested in the good housekeeping aspect.

Garbage cans. These unromantic but necessary articles also concern the health department. It is recommended that they travel by freight elevators, not through corridors and kitchens, and be kept covered when not in use. One satisfactory method of caring for them is to subject them to live steam followed by chlorine after daily disposal of garbage.

Supervision of post-mortem room. This falls within the field of the hospital administrator who may very profitably consult with the health department in matters relating to the sanitation of this room. No great powers of imagination are required to visualize this room as a possible source of infection if badly located and improperly kept.



Associated Screen News, Montreal Collecting a sample for inspection.

The danger of spread of typhoid fever and the dissemination of tubercle bacilli from fresh anatomical specimens is worthy of consideration.

These factors relate directly or indirectly to the healthful environment of the patient and are of equal concern to both hospital and health department. Both have further responsibility concerning those persons who are employed in the kitchens and laundry. Consideration must be given to the periodic health examination of all such employees together with a definite policy regarding health education of this group. In this field, as in all others, good relations between hospital and health department assist in achieving health objectives which are of mutual benefit.

The teacher in the school of nursing, placing increased emphasis on health as a way of life, may use to the fullest extent the facilities of the health department. Health education material and statistical information are available as well as the specialized services which the department provides. As she develops her program in relation to individual health, hospital, home, school and industry, the instructor will seek from the health department educational material and posters suitable for use in the classroom and out-patient department. If the health department is adequately staffed with trained personnel, it should be able to meet the growing demand to take part in the basic preparation of nurses by offering opportunities for student affiliation.

In thinking of student nurses, it is interesting to note that not infrequently it is the public health nurse from the health department who first stimulates the interest of the high school student in nursing. The health department is concerned with the housing of that student and provides by-laws governing health and safety. Where the nurses delight in their own swimming-pool, the health department is responsible for the safety of such water.

If we turn now for a moment from the hospital and think in terms of the health department, we might consider briefly just how it carries on where the hospital leaves off. A close working relationship and joint planning mean better service to the community. The newborn infant, having received the best of care in hospital, is discharged. Then comes the need for infant welfare services in the community. An adequate program assures every baby of regular health supervision and immunization against specific diseases. This may be done either by the family physician, private agency or the official health department. As the child grows, interest in his physical and emotional health should be reflected in the health department's services, the education of parents, teachers and children and the provision of facilities for diagnosis and prevention of disease.

While the hospital is caring for the patient with syphilis, gonorrhea or tuberculosis, it is the aim of the health department to co-operate with the hospital

and with private and official agencies in the follow-up of contracts. It is reasonable to expect the hospital to be interested in what the health department is doing to secure an educated public opinion, the enforcement of legislation and the provision of facilities for diagnosis and control,

In conclusion, we may think of nursing as a symphony of service, whose constituent parts are specialized groups that by themselves can be limited, but working together with understanding can practise harmoniously the art of nursing in its fullest sense. As we strive to understand and develop the relationship between the hospital and the health department it seems reasonable to emphasize the importance of more planned contact between them. This would undoubtedly result in more uniformity of health teaching, the maintenance of higher standards and more adequate care of patients. These ends are surely worthwhile in themselves; but in addition would also have a decided bearing on the better preparation of nurses.

Foot Health and Disease

ATLANTA S. SOLLOWS

When our remote ancestors deserted the tree as their place of abode and began to walk in an upright position, the foot as we know it today took form and shape. Structurally very similar to the hand, the digits have become shortened through the centuries and the great toe has lost some of the power it once had. The ankle developed larger bones than the wrist because of the necessity of carrying the weight of the body. The twenty-six bones of the foot are held together by ligaments and muscles in such a way that they are suited not only to support the body's weight without tiring but also to give a certain degree of elasticity to the stride. The bones of the foot are connected with the large muscles of the leg by means of long tendons which are bound down at the ankles by bands of ligaments. Thus the powerful movements of the leg muscles are transferred to the foot and walking is made possible.

The bones of the normal human foot are so arranged as to form well-defined arches. The longitudinal arch extends from the heel forward to the ball of the foot on the inner side, and is commonly called the instep. The transverse or anterior arch is across the ball of the foot back of the toes and at right angles to the horizontal arch. The position of the

bones comprising these arches depends upon the support given them by the exceedingly powerful ligaments which bind them together and the supporting muscles on the soles of the feet. If these muscles become flabby through lack of use, the weight placed on the ligaments causes them to stretch, letting the bones down. Care in preserving the normal arch is, therefore, of primary importance in promoting foot health.

In the normal foot, the weight-bearing areas form a triangle whose base is the transverse arch. With the weight thus distributed upon the heel, the ball and the outer edge of the foot, the position of greatest strength and spring in the stride is when the toes are pointing straight ahead. Where there is a weakened arch the foot tends to swing outward and the centre of gravity then passes through the middle of the longitudinal arch. The arch is highest here, less well supported by ligaments and not suited to bearing a weight. The effective use of the great toe and transverse arch is lost.

The cause of most ordinary foot troubles is improperly fitting shoes, with too short stocking-feet a close second. Vanity, thoughtlessness, carelessness are all contributing factors. The people who think they must wear excessively high heels because of an abnormally high instep are numberless. Nurses who have to be on their feet for long periods of time should look for the following in choosing a shoe:

- 1. An approximately straight inner line from heel to toe. Stand in front of a mirror and note the straight inner line of the foot. If there is an inward or outward flare shoes must be adapted to this but the average foot is straight.
- 2. The front part of the shoe should be as broad as the foot that wears it. The measure of the breadth should be taken in a standing position when the weight has spread the transverse arch to the full extent.
- 3. The heel of the shoe should not be over an inch and a half in height and should be as broad on the wearing surface as the heel that will rest upon it. Rubber heels are de-

cidedly preferable for general wear on hard floors and pavements to relieve the body of jar as much as possible.

4. The shoe should have a combination last in order to fit snugly over the instep and heel, loosely over the toes.

FOOT DISEASE

With 110 possible foot diseases and minor deformities, it is not surprising that recent surveys in schools and health clinics have disclosed the fact that there is an increasing number of minor foot ailments. Of children up to ten years of age, 14 per cent were found to have some foot defect. From eleven to eighteen years, 88 per cent of those examined were foot defective in some degree. It is estimated that there are approximately 3 pairs of perfect feet in ten thousand children from 6 to 18. Among the whole adult population of Canada it is doubtful if there could be found a dozen pairs of absolutely perfect feet!

At least fifty of the foot diseases are of an infectious nature. Verruca, a benign, highly vascular neoplasm is caused by a specific, filterable virus. The growth seems to be carried into the surrounding tissues through the medium of the lymphatics, thus producing multiple verruca. There are several types, the most common being rough, fissured, cauliflower-like in appearance. A cross section of this growth shows elongated papillae which are encased individually in epithelial covering. This covering is of the stratified squamous type. In some types of verruca the resemblance to epithelioma is very marked. Occasionally, late syphilis takes on a papillary appearance which might be mistaken for verruca. Heloma molle, the soft, macerated slightly yellowish overgrowth, is located usually upon the interdigital surfaces. A careful differentiation should be made between the true heloma molle and secondary syphilitic lesions, the latter also occurring as squamous patches between the toes.

Of the thirty-three constitutional or systemic diseases in which foot symptoms

may occur, none gives as much concern as diabetes mellitus. This is chiefly because the sequelae are frequently tragic. Helomata of all types may be found on the feet of diabetics. In some, the skin is dry and fissured, the nails show loss of transparency and assume a yellowish color with onychauxis; others complain of tingling or numbness of the toes, and in advanced cases there is cyanosis and loss of dorsalis pedis pulsation. Caustic corn remedies are dangerous things at all times, but too much stress cannot be placed upon the hazard entailed in their use by diabetics. In the care of diabetic patients, nurses should be on guard to prevent the development of ingrowing toe-nails. Bathing the feet with hot saline solution, to which a teaspoonful of soda is added, helps to reduce the risk from calluses or corns. As a further protection, the toes are painted all over with metaphen every week.

Contrary to general belief, it is not considered advisable to cut the toe-nails straight across. It is doubtful if the people who advocate this ever stopped to think why they do it. When the nails

are cut in this way, a sharp tip is left which grows into the soft nail groove causing irritation and possible abscess. The nail naturally spreads as it reaches the distal end. It may be appreciably wider than at the matrix so to avoid such complications as ulceration, diffused cellulitis, proud flesh, etc., it is sensible to cut all of the nails with a gentle curve to the tip of the toe and slightly rounded at the corners.

For the adequate treatment of these and all the wide range of foot disorders one of the younger members of the healing arts, chiropody, has been recognized by legislative enactment in several provinces and is regulated and controlled by Boards of Registration, This is an interesting specialty to which nurses might turn with an assurance that, when qualified, they would be capable of rendering a great assistance to a footsore humanity. The only school in Canada where training can be secured is located in Saint John, N.B. The writer would be glad to answer any enquiries regarding the course. The address is 156 King St. E., Saint John, N. B.

Hospital Administration Course

During each of the past two years, one of the projects of the Alberta Association of Registered Nurses has been a short course for nurse administrators of small hospitals, sponsored by the School of Nursing, University of Alberta. The course covered a period of two months. Applicants had to be registered nurses in good standing. Matriculation was not required. This enabled many nurses to attend who otherwise would not have been able to take such a course at a university due to deficiencies in educational requirements. Certificates of attendance from the University of Alberta were granted to those who satisfactorily completed the course. A fee of one dollar was required for registration at the University. The actual costs were met by the Federal Grant awarded to Alberta. Expenses, such as living, etc., were of course the responsibility of the student.

The administration of the course was in the hands of a group which included the director, School of Nursing, University of Alberta, the president, registrar and representatives from the Alberta Association of Registered Nurses. The adviser was Dr. A. C. McGugan, medical superintendent, University of Alberta Hospital, who is also a member of the School of Nursing Council, University of Alberta.

The course was planned to assist inexperienced nurses to understand the principles of hospital administration and the problems of small hospitals; to assist them to adjust and adapt to this specific field of nursing; to assist them to meet problems of personnel, board and community relationships; to interpret the legal aspects of hospital administration; to broaden their knowledge regarding newer nursing and medical procedures.



Housez Studios, Edmonton The class in administration.

In Alberta there is an extensive system of small hospitals staffed by registered nurses and under the administration and supervision of nurse superintendents. Basically, the course was to be of general assistance to these administrators in carrying out their many duties as business manager; purchaser of supplies; director and supervisor of nursing, operating room, case-room, x-ray, laboratory, dispensary; dietitian; housekeeper; personnel manager and guide.

Lectures were planned to include a wide variety of topics, such as: purchasing; hospital accounting; records; food service and nutrition; hospital housekeeping; burial preparations and requirements; and a general review of the work carried on in the various hospital departments. The relationship of the hospital to the public health department was reviewed. Two days were devoted to observation at the Provincial Mental Hospital at Ponoka.

Lecturers included: leading members of the medical profession interested in the problems and difficulties of the rural hospital; members of the University Faculty; members of the Public Health Department responsible for supervision and inspection of small hospitals in Alberta: instructors and ward supervisors from schools of nursing; hospital personnel, including dietitians, x-ray technicians, record librarian, purchasing agents, business managers and engineers.

Weekly conferences under the supervision of the director of the School of Nursing, University of Alberta, were conducted and planned by the individual students who had been instructed in the value and technique of staff conferences.

A questionnaire was submitted to each student for constructive criticism of the course. The general concensus of opinion was that the course fulfilled a great need. Two months appeared to be a satisfactory length of time to permit the active learning. It was demonstrated that there was a definite need for a more intensive course in x-ray technique as this often is the responsibility of the superintendent. A more complete understanding of Provincial rules and regulations governing hospitals was also felt to be desirable.

Nova Scotia Refresher Course

A very stimulating refresher course was conducted by Miss Mary Mathewson, assistant director of the McGill School for Graduate Nurses, in the early Spring under the auspices of the Registered Nurses Association of Nova Scotia. In order to reach as wide a group of public health nurses as possible, at the conclusion of a very successful week in Halifax, Miss Mathewson repeated the course in Sydney. Supplementing the material presented by Miss Mathewson, which included such topics as Ways and Means of Improving our Service and our Teaching, Family Health Service, etc., Miss Juanita Archibald, provincial nutritionist,

spoke on Nutrition, and Dr. Hiltz and Dr. Beckwith discussed the problems related to Tuberculosis. Miss Electa MacLennan, assistant secretary, Canadian Nurses Association, gave an interesting insight into many of the developments in Canada.

Numerous social events were arranged which provided the opportunity for the nurses to meet our guest speakers, to renew old friendships and to make new acquaintances.

Altogether, the whole refresher course was well worth attending and should help each of us to do a more effective job which will be reflected in the increased health and welfare of our communities.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A

Preparation for Psychiatric Nursing

HILDA BENNETT

Dr. Stevenson has drawn for us a comprehensive picture of psychiatry and mental hygiene in the post-war period. I wish to discuss a plan for preparation

for psychiatric nursing.

Inadequate knowledge of mental hygiene, psychiatry and psychiatric nursing by professional nurses is a recognized fact. The need for the inclusion of these subjects in the curricula of training schools has been realized for many years. The need, due to the war, is greater than ever. Let us recognize the need and plan how to meet it.

There are at present four methods of preparation for psychiatric nursing: (1) In psychiatric hospital schools of nursing (two years, psychiatric hospital; one year, general hospital); (2) affiliations between general and psychiatric hospital schools (three months); (3) experience for undergraduates in psychiatric units attached to general hospitals; (4) post-graduate courses in psychiatric hospitals (six months).

These methods, on analysis, are generally conceded to be inadequate. The few psychiatric hospital schools now in operation do not graduate sufficient nurses to provide adequate staffs for their own needs. Thus there is no surplus of graduates with psychiatric preparation for general hospital staffs.

But you may ask "Why do we need nurses with psychiatric preparation in

general hospitals?" In the Globe and Mail, April 6, 1945, was an article entitled "Wider Knowledge of Mental Ills is Seen as Need". The following statement is quoted from the Canadian Medical Association Journal: "Inadequate knowledge of mental and neryous diseases is possessed by general medical practitioners in Canada". The article dealt with a study, made by the Canadian Army Medical Officers, of psychoneurotic ex-service men and women, and their attempts to re-establish themselves in civilian life. Psychoneurosis has been the cause or contributory cause of about one-third of all medical discharges from the Canadian Army. The article noted that the psychoneurosis group comprised 15 per cent of all medical discharges and that another 15 per cent were ill with a variety of psychiatric conditions. The article goes on to question whose responsibility it is to educate and retrain this large group. Granted the criticism is levelled at the medical profession, but is it not equally a criticism of the professional nursing group? Should we not accept it as a challenge?

As professional nurses, we must realize that the care and retraining of psychiatric patients is our responsibility. Nor does our responsibility end there. The teaching of mental hygiene, as a preventive measure in our everyday contact

with all patients and all people, has been too long neglected. Psychiatric nursing is as old as nursing, but we have not included it as an integral part of our teaching in general nursing. Once again emphasis is being placed on the need for the care of a large group of mentally and nervously disturbed members of society; added to the old responsibility is the unquestionably greater responsibility - prevention; to educate our people how to maintain a healthy mental life. This, then, is the answer to the question of why we need nurses in all hospitals to have preparation in mental hygiene and psychiatric nursing.

Let us survey what is being done today to prepare nurses for psychiatric nursing. In 1943-44 there were approximately 5,300 student nurses in the sixty-five schools in Ontario. Six of these schools are in psychiatric hospitals where the total student enrolment was about 225 students. Of the 5,100 students in general schools, 123 affiliated in psychiatric hospitals — 83 in Toronto Psychiatric Hospital and 40 in Ontario Hospital, London. The affiliating students were from 18 schools — 41 schools have no psychiatric affiliation. The University of Toronto School of Nursing is the only school arranging a psychiatric affiliation for all undergraduates in the school. This school also integrates mental hygiene with the general nursing throughout the whole training.

You may say that there is not a sufficiently large clinical field in which to give all students a three-months affiliation. That may be true under existing circumstances but have we made an urgent demand for the clinical field to be broadened? How can we go about creating a clinical field? First, we must be convinced that psychiatric nursing is not a specialty but an integral part of general nursing and should be incorporated in every graduate nurse's preparation. Second, we must draw up a plan. Third, convinced of the need, and having a workable plan, it is not a very daring step to demand a clinical field.

Dealing with these points in turn, are we convinced that psychiatric nursing should be an integral part of the preparation of every professional nurse? More and more it is being realized that the so-called normal patients are not normal — the majority of those who are physically ill have nervous disturbances in varying degrees, and should be treated with understanding. Only an emphasis on mental hygiene throughout the training can give the understanding that will help to restore patients to society as well adjusted individuals.

The plan for integrating mental hygiene and psychiatric nursing with general nursing in essence is taken directly from the "Proposed Curriculum for Schools of Nursing in Canada." Briefly, the outline is this:

1st year — Theory: (1) A good basic course in normal psychology in the preliminary period; (2) a good course in mental hygiene; (3) psychiatric interview with the student — health examination; (4) emphasis on mental hygiene in all classroom lecture courses.

Practice: In the period of supervised practice on medical and surgical wards when theory and practice are being correlated, an opportunity is afforded for an early application of the principles of mental hygiene.

2nd year — Three months affiliation in a psychiatric hospital. Theory: Psychiatry; psychiatric nursing including occupational therapy, and hydrotherapy; neuro-anatomy and neurology.

Practice: Experience on wards and in the out-patient department; home visits with the psychiatric social worker; clinics, individual and group conferences, group discussions.

On return to the home school — Theory: Advanced course in mental hygiene.

Practice: Teaching and supervision in all departments to include the application of the principles of mental hygiene to all aspects of nursing. Group discussions of patients in hospital and the community will give an added emphasis to mental hygiene aspects. Health teaching should be closely allied to all mental hygiene teaching.

This outline pre-supposes members

of teaching staffs, supervisors, head nurses, in both psychiatric and general hospitals, who have had general hospital training integrated with psychiatric preparation. Naturally the question arises "Where are all these supervisors and teachers to be obtained?" They cannot be prepared overnight. This will be a gradual development, too gradual for the peace of mind of those who are familiar with the present great need in the field of psychiatric nursing. We could start by integrating psychiatric and general nursing. In three years time we could, in Ontario, have over five thousand graduate nurses with an appreciation of the meaning of psychiatric nursing. With our present set-up of teaching staffs with no psychiatric nursing preparation, the preparation of those five thousand graduates would be far from perfect, but it would be an encouraging beginning. Post-graduate courses have offered organized lecture courses in psychiatry and psychiatric nursing, combined with ward practice. It is interesting to note that many of the graduate students in these courses were members of staffs of psychiatric hospitals who, realizing the great importance of understanding the treatment of psychiatric patients, desired more advanced study than their years of experience had afforded. During these years of war the post-graduate groups have dwindled. This in part is due to war conditions, but candidates for clinical supervision courses are still applying for entrance to other clinical courses. Thus we are forced to conclude that it is due to lack of knowledge. We have then the picture

of hospitals admitting more and more patients who need psychiatric care, and less and less nurses with psychiatric preparation to provide that care.

To fill the needs for graduates with psychiatric preparation, we must fill the post-graduate classes with our prospective teachers, then place them in charge of the units in mental and general hospitals where students are to receive their practical experience. This will take time. If the clinical field for graduate students is inadequate, we must make the demand for a broader field. It is fairly generally agreed that psychiatric hospitals would best be used as clinical fields for undergraduate and post-graduate students. Thus, gradually, the psychiatric hospital schools would be eliminated.

Now for the third point — demanding the clinical field. At the present time students from nine schools in Western Ontario are affiliating in the Ontario Hospital School, London. The Toronto Psychiatric Hospital also has affiliation arrangements with nine schools.

The demand for affiliation has not yet taxed the available field. As need for a wider field is demonstrated, other psychiatric schools can be approached. But the *demand* has not been made. It is not for the psychiatric hospital schools to go to the general hospitals to try to sell their fields. It is for the general hospitals who so sorely need that field to go to the psychiatric hospital schools with a plea for the valuable experience which the general hospital nurse so much needs, and which the psychiatric hospital school has in such abundance to give.

Nursing Sisters' Association of Canada

The Calgary Unit reports an active year during 1944 with a membership of thirty-eight. Meetings were held monthly at the homes of the various members. On several

occasions nursing sisters of the present war were welcomed. Activities for the year included making Red Cross dressings, helping at the Blood Penor Clinic, Blood Typing Clinic, War Savings Stamps Bar, and at the Red Cross Reception Centre. Donations were made to the Mrs. Churchill War Fund, Ditty Bag and Canadian Legion Christmas Tree funds. A successful rummage sale was held as well as a draw for a hand-woven suit length donated by one of the members. The proceeds, which amounted to \$300, were used to furnish a room for nursing sisters in the Col. Belcher Hospital. Recently Miss N. Gunn, the president, and her committee presented the key and contents to Dr. Park,

district administrator for Veterans Affairs. In accepting this gift from the Calgary Unit Dr. Park commended the nurses of the 1914-18 war for remembering the nursing sisters of the present war.

Alma Froelich, matron of the Col. Belcher Hospital for some years, retired at the end of the year. The Unit lost three of its members when Mrs. Harding Priest moved to Toronto, Mrs. D. Dall to Ottawa, and Mrs. G. Grout also left the city.

Institutes in Saskatchewan

Very successful institutes for members of the public health, general nursing, and hospital and school of nursing sections were held in Regina and Saskatoon the latter part of February.

The public health refresher course was convened by E. Smith, director of Public Health Nursing Service, Regina. Advantage was taken of the intensive course in Venereal Disease Epidemiology conducted by the Department of Public Health under the direction of Capt.C. G. Sheps. This constituted the course for all public health nurses. By special invitation nurses attending the other refresher courses also attended several of these sessions. Alice Kresge, director of field work, Institute of Syphilis, University of Pennsylvania, was one of the

principal speakers and the guest of the S.R.N.A.; also Orma J. Smith of Kerrobert.

Miss Smith spoke at the joint refresher course for the general nursing and hospital and school of nursing sections on "The rural hospital — its attractions and opportunities." Other interesting session included "Newer drugs", a round table on psychiatry and simplifying procedures, and other topics. The joint refresher course for the general nursing and hospital and school of nursing section was convened by E. James and M. Chisholm of Saskatoon. Mrs. Helen Martin of Regina and Eileen Sheffer of Saskatoon were co-conveners.

Over one hundred nurses attended in each centre. Representatives from many parts of the province were included.

Laundry Process Utilizing Sea Water Developed

A process which makes use of sea water for laundry purposes has been developed, and will soon be in use on all army hospital ships. In initial experiments the United States army hospital ship Wisteria, was selected for a practical test at sea, and in a thirty-day period, 36,101 pieces were successfully laundered with sea water. This meant a saving of about two-thirds the linen inventory carried by hospital ships, or room for four more bed patients or ten more

walking cases on each ship. The saving effected in fresh water was 4480 gallons a day, and the reduction in amount of linen used represented a considerable financial saving. The process can be installed in any ship's laundry by cutting in the salt water pipe. Its use on troopships and island bases is also contemplated.

Office of the Surgeon General Technical Information Division Washington, D. C.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses
Association

Mental Hygiene Problems in Generalized Public Health Nursing

EILEEN CRYDERMAN

Public health nursing is not a service complete within itself, but exists only as an essential part of the general public health program. Its function is to augment any part of this program where the dexterity of a skilful nurse will contribute to the safety and comfort of the patient, and where teaching on an individual, family or community basis, will contribute to the prevention of disease and promotion of health. In the field of mental health, the necessity for active promotion of positive health is being more and more recognized. The public health nurse has a strategic and unique position to aid in this program, as few other community workers have entry into as many homes as she has. In analyzing some of the mental hygiene opportunities met in the public health nursing field, let us consider them from the standpoint of the group we serve.

In order to more clearly understand who we, as public health nurses, serve, may I outline what a generalized program of today includes: maternal health (pre-natal and post-natal); infant and pre-school health; school health; adult health; industrial health; communicable and non-communicable disease (in this are included mental disease, tuberculosis and venereal disease). All these services together form a well rounded public health nursing program. In this outline,

I have not mentioned mental health and hygiene as separate divisions of our work. They are woven so integrally into each branch it would be impossible to separate them. May I take some of the sections and attempt to show where our opportunities lie.

Maternal Health: If we, as public health nurses, are to be successful in helping not only to lower the maternal mortality rate but also to contribute to the mental health of the mother "by applying knowledge of human behaviour to all professional services", we must have an understanding of the emotional factors in the whole maternity cycle, including fears, superstitions, prejudices of the patient, family attitudes and adjustments. We must realize that failure on the part of the expectant mother to go to her physician for advice frequently is based on causes other than ignorance of the need for this care. Her attitude may result in a rejection of the pregnancy because of inadequate finances. Other causes of fear may be: poor health on the part of either parent, especially the mother; fear of pain and labour; fear of transmitting handicaps either mental or physical; unsatisfactory relationships between parents; unwillingness to go to a public clinic; the size of the family; difficulties in a previous pregnancy.

We must remember that the mother's

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attitudes are a reflection of her relationship to the other members of the family and the community. Today we are recognizing the need to help the father and the family, as well as the mother, to make necessary adjustments. The father's acceptance of the pregnancy can do much to help or hinder the mother's adjustments. The nurse should be ready to help both parents appreciate the need for preparing the other children in the family for the arrival of a new baby. Hostility toward the new arrival may be normal, and the children must be helped to make this adjustment.

Infant and Pre-School Health: In no phase of the public health nursing program is the need for mental hygiene more in evidence than in the work with the parents of infant and pre-school children. It has been stated that "education begins at birth and is a gradual process throughout life". The nurse needs to realize that certain factors, such as the significance of early feeding and handling of the infant, are sources of satisfaction to him and a basis for the early relationship between mother and child; that so-called problems of the preschool period are, in fact, stages in normal development through which all children pass. The work of the nurse is to help the parent to give the child the sense of security which comes from being wanted and loved, and which is basic for normal development. To really give this, the parent himself must feel secure and happy, for children soon absorb the tensions which are in the home. The public health nurse should have learned to regard feeding, nail-biting, thumb-sucking, and other problems which occur in this period, not as problems in themselves but rather as evidence or symptoms of a disordered home to which children react by the presentation of abnormal behaviour. We have not always been able to give as much help as we should have, but we should work toward this goal in our infant and pre-school centres and in our home visiting program. We should recognize our own limitations and be prepared to seek help.

School Health: It has been stated that the school health program "is that phase of service which considers the well-being of the school-aged child and his education for healthful living. It is one of the units of health work which is essential to a well-rounded program for family and community health". An enlarged concept of school nursing shows the nurse carrying on a co-ordinated health program which includes the home, the school and the community, and dealing with the health of the entire family, mindful of the needs of the child. Here she is in different position than in her other branches of work; her immediate co-workers are members of a different profession. Much of the success of her work depends upon her attitudes, relationships and her ability to work with other people.

In her individual and classroom conferences she acts as a liaison officer, helping the teacher estimate the load the individual pupil can carry in the light of his mental equipment, home environment and responsibilities. She can be of help in developing a healthful environment in the school, not only physical but emotional. She should be alert in interpreting the influence physical defects may exert on emotional development, in such cases as eye, hearing, speech and orthopedic defects, in left-handedness, and in such diseases as diabetes and epilepsy. She can discuss with the teacher how to detect early symptoms of emotional or social disturbance in pupils and how to use available sources of help. Some of the many types of behaviour difficulty referred to the nurse include: avoidance of group, daydreaming, temper tantrums, extreme shyness, sex misdemeanours, enuresis, swearing, quarrelling, lack of application, destructiveness. The nurse's responsibility in helping meet the needs of these children depends upon the resources of the community. In many of the larger centres there is a

mental hygiene service with a psychiatrist and a psychologist. After referring the child to this service she may help by providing a social history, giving as complete a picture as possible of the child, his development, interests, personality, family and home. She may aid appreciably in carrying out the recommendations of the psychiatrist by interpretation both in school and home.

Adult Health: In this field the public health nurse should assume much responsibility and should display her resourcefulness and initiative. Not infrequently, we have an opportunity to see and talk with individuals who present more or less serious mental maladjustments. Here, again, the public health nurse must recognize her own limitations as a psychiatric worker. When she finds people who present many physical symptoms which have no pathological foundation, or who seem to have many anxieties, become easily depressed or irritated, it is well to find out what the trouble may be. The nurse may be able to help the patient to realize he is ill and to want treatment. At times the family needs as much help in understanding the behaviour of the individual as the patient himself. At other times the patient may be too ill to co-operate and the nurse has to work through the family alone. Contributing in the recognition of potential mental illness should be a challenge to all public health nurses.

Illness: Under this section many different types of illness and disease and our mental hygiene problems in relation to them could be considered. Tuberculosis is one that plays a very important part in our program so let us use it as our

example.

Every nurse knows that, despite public education in regard to tuberculosis, she still has to deal with many problems of emotional non-acceptance (fear of the disease itself, a feeling of ostracism by members of the family or others in the

community). We must also recognize in situations where a parent is affected that we must deal with the problems which we find in any broken home. If the father is ill, there is the problem of income. If the mother is ill, who will care for the children in the home? A dual responsibility is placed upon the parent left in the home and the relationship of one parent to the other is altered.

Tuberculosis affecting the adolescent or young adult must be reckoned with as a complication in the individual's ability to make his total adjustment. Tuberculosis contracted at the age of fifty is one problem, but at twenty requires a different mental adjustment. In addition to the problem faced by all tuberculous patients, the youth must decide on such issues as vocation, marriage, paternity, etc.

In outlining some of our problems and opportunities in mental health work, I have attempted to prove that mental hygiene is an integral part of all our work. Perhaps, at times, this fact seems to be a somewhat intangible one and is still difficult to associate with our practical needs. If so, this is partly because in our whole background of training, the emphasis has been on physical rather than mental health, and although this emphasis has undoubtedly changed and is continuing to, we ourselves feel insecure. We must remember that mental hygiene is a community responsibility, and we, as one of the groups of community workers, have a real responsibility. In concluding, may I quote from an article in Public Health Nursing: "Mental hygiene is a vital part of the nurse's equipment, and it weaves itself into the pattern of her daily activities with infinite variation. It colours her approach to her patients. It fosters her understanding of them. It enlarges her knowledge. In every aspect of her work it enables her to render better service, more helpful to her patient, more satisfying to herself'.

There is three times the amount of vitamin C in the peel of an apple than there is in the flesh.

-Ohio State Medical Journal.

The Soviet Union Controls Epidemics

Among the striking contrasts between Czarist Russia and the Soviet Union is the health of the population. Old Russia was notorious for its uncontrolled epidemics, particularly in time of war. During the present war it is reported there have been no epidemics in the Soviet-controlled areas.

In the last war, more Russians were killed by typhus, the disease of poverty and dirt, than by enemy gunfire. Typhoid fever, dysentery, smallpox, trachoma, cholera and plague were as common as rainfall. These diseases were accepted as a natural part of life. Children died like flies and so did women in childbirth. The superstitious regarded epidemics as a punishment from Divine Providence.

The Soviet government began in 1918 to organize public health services. But their application on a broad scale was delayed by the civil wars and intervention which followed the World War. It was not until the beginning of the Five-Year plan in 1928 that satisfactory coverage of public health measures was begun.

It is, therefore, a remarkable achievement that in less that two decades the Soviet health authorities reported complete elimination of smallpox, cholera and plague, and that they brought under control typhoid, typhus and other diseases that were rampant in old Russia. An article in the February issue of the American Review of Soviet Medicine details some of the methods that were used. In the Czar's army, vaccination against typhoid was forbidden. The Soviet government introduced a program for regular immunization of the civilian as well as military population and at the same time established sanitation and food control.

Millions used to die every year from typhus in the old days. The 1914 war was followed by the blockade, interventions, civil war, famine, scarcity of fuel and soap, and a broken-down transportation system. These factors helped to spread the infection to an

unparalleled extent. The Czarist regime had provided no hospital facilities for typhus patients. In 1920, among the first acts of the Soviet government was the provision of 250,000 beds for typhus patients. It set up an extensive network of stations for observation, isolation, and disinfection. Millions of pamphlets, leaflets and posters were distributed in all languages of the U.S.S.R. Hundreds of thousands of volunteers were enlisted in the war against typhus. Slogans were broadcast and "bathing weeks" instituted. The government allotted generous funds for this work and typhus has been no problem in this war.

Diphtheria and measles have received special attention by research and practising public health workers. Both these diseases of childhood have been brought under complete control. Immunization against diphtheria is compulsory for all children between the ages of one and eight. In 1940, ten million children were immunized against diphtheria. During the war, the public health centres all over the country have conducted a program of re-immunization and research workers are searching for a more effective preparation which would require less frequent injections.

Measles used to strike at millions of children in old Russia. It no longer threatens that many. Soviet medical workers began to use anti-measles serum when it became safe and by 1937 the use of such serum became obligatory throughout the U.S.S.R. In 1940 alone, 1,241,000 children were immunized against measles. The inoculations are given free to all children. "The aim", it is stated in the Soviet health report, "is to raise the age of measles patients, and create an immunity by developing an abortive form of the disease. Soviet scientists are now searching for methods of active immunization against measles. Some experiments have yielded encouraging results".

- Toronto Daily Star

Previews

Patients are frequently baffled by the regular battery of laboratory tests to which they may be subjected in the process of reaching a diagnosis. In phrase-ology so simple that the lay person may understand Dr. Watson Sodero has described the principal tests for us.

Have you been pestered by your

deafened friends for an expert opinion on the possibility of having their hearing restored by the delicate fenestration operation? That your information may be thoroughly authentic Dr. William McNally has prepared a description of the operation for us. Bernice Stewart outlines the required nursing care.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

Red Cell Paste in Treatment of Ulcers

ERNA E. HARTZ

Interest in this procedure developed after an interne at our hospital, the Saint John General, applied the red cell paste to varicose ulcers that we had been treating for a period of twelve weeks without success. In less than five days, six of the superficial ulcers were healed completely and in two weeks the patient was discharged from the hospital. This treatment was first used in a naval hospital in Philadelphia when someone wanted to make use of the red blood cells which are important by-products of plasma production. These cells were administered first as red cell infusions to patients suffering from anemia. Later two doctors used the red blood cells on a decubitus ulcer of long standing, but the problem of making these cells adhere to the wound presented itself so a sterile paste was prepared.

Preparation: The red blood cells which remain after the plasma has been aspirated should be fresh type "O" cells, a universal group, so they can be used on any person regardless of their blood type. The paste is made by dusting powdered tragacanth, a gummy exudate of plant origin (astragalus gummifer) into a herylresorcinal solution. The herylresorcinal is a germicide which is very strong but does not harm tissues. This mixture after several hours forms a gelatinous mass and is then ready to mix

with the red cells. After thorough mixing by agitation the paste is stored at from 2°—5°C. while not in use. An analysis of the composition of the paste reveals eight to ten million red blood cells and two to three thousand white per cubic millimetre. The hemoglobin is varied, from 28 to 31 gms. per 100 cc.

Method of Application: During the treatment the wound is cleansed with isotonic solution of sodium chloride and dry gauze; the paste is then applied with sterile cotton applicators. Ulcers are treated by applying a thin film of paste over the area which is allowed to dry before being covered with a sterile dry dressing. Infection developing, the crust is removed, the wound cleansed lightly with isotonic solution of sodium chloride and a second application of the paste is applied. A sterile scab soon develops under which epithelization takes place. In deep granulating wounds the paste is applied in relatively large quantities, after which the wound is covered with a sterile dry dressing. When the wound is re-dressed, it may be noted that a rather large quantity of the paste is absorbed by the affected tissues, the discharge decreased and the granulation takes on a healthy appearance.

Nursing Care: The wounds are dressed either once or twice daily, depending on their condition and progress. This eliminates a lot of nursing care as usually ulcers have to be dressed more often than twice a day. After the ulcers are progressing well the dressing does not have to be changed for several days.

Results of Treatment: During the past few months ten cases of varicose ulcers have been beneficially treated with red blood cell paste. Only one case failed to heal and it was a syphilitic patient. This is a very small number of cases, but it would almost seem that the paste works only in straight varicose ulcers. It must be remembered that this method is only a means to promote local healing. Other procedures, such as

ligation and injecting of veins, should be performed when indicated.

Comment: How this red blood cell paste works has not yet been determined. The most plausible theory is that required nutritional elements or proteins are supplied to tissues which may be deficient in these substances because of inadequate circulation. The red blood cells appear to be absorbed to a certain degree by the tissues until the granulations reach the surface and a crust forms. This crust serves as a support for new connective tissue. When the crust finally drops off the surface is completely healed.

Methods of Pasteurization

To kill germs that possibly have invaded raw milk and have made it unsafe to drink, it must be put through a protective process called pasteurization.

Commercial pasteurization of milk for direct consumption involves a process of heating it to a temperature not lower than 142° F and not higher than 145°F for not less than thirty minutes. The milk is then cooled — lowered to 45° within forty-five minutes.

This process can also be carried out in the home — in a smaller way, of course. In sparsely settled areas where pasteurized milk is unobtainable, home pasteurizers should obtain a heavy aluminum container with faucet attached about two inches from the bottom. Also needed is a removable metal rack which should clear the bottom of the container by about 1½ inches. The container should be deeper than quart bottles which can be used to hold the milk. An armored thermometer also is needed.

The filled bottles of milk with the thermometer inserted through the cap of one bottle are placed in the container, in cold water about an inch from their tops. When the thermometer reaches 145°F, the heat is reduced so that the thermometer reading remains between 142° and 145° for thirty minutes.

All virulent disease germs will then have been killed and, if ice or snow are available, the water should be drawn off a little at a time and ice or snow added, until the reading is 45°. The milk is cooled to 45° be-

cause that is the temperature at which it keeps best.

Another home pasteurization method used in farms homes is to heat the milk to a boiling point and then immediately cool it. More care has to be exercised in cooling until the temperature falls to about 100°.

-Health News Service

Siamese Twins

An interesting and unusual delivery occurred recently in a northern Ontario town. The mother, aged nineteen, was a primipara She was in labour when she reached the hospital. Her physician diagnosed twins and after two hours decided to do a Cesarean section. The patient was delivered of female twins, weighing ten pounds. They were united from the breast line to the umbilicus, and had a single cord and placenta. They appeared normal in every respect. They did not breathe. The specimen has been sent to the museum at Queen's University. The mother is recovering.

We have been wondering if other Siamese twins have been born in Canada and, if so, where. Dorothy Fox (Toronto General Hospital) and Christine Cameron (Royal Alexandra Hospital, Edmonton) and I were present at the operation.

L. CLARA PRESTON
Superintendent, St. Paul's Hospital
Hearst, Ont.

Postwar Planning Activities

Contributed by

POSTWAR PLANNING COMMITTEE OF THE CANADIAN NURSES ASSOCIATION

How Can Nurses Fight for Peace?

LAURA HOLLAND

Germany has "unconditionally surrendered". Peace has been declared. The heart of every Canadian rejoices that organized warfare in Europe has ceased, but we all realize that although peace has been declared it has not yet been won, and the extent to which true peace can be realized will depend on the attitude and actions of every individual throughout the world.

It can be assumed that members of the Canadian Nurses Association are following with keen interest, and it is hoped with objectivity and without prejudice, the activities of the United Nations Organization, and that they will contribute in devious ways to local and national rehabilitation and reconstruction plans and programs. That is a duty, as well as an opportunity, that concerns every Canadian. As an Association, however, we have an inherent responsibility to help put into effect those principles and practices that must be exercised by each and every profession if the type of peace that our men and women in the Services have fought and died for is to be achieved.

Already our Association, through its national, provincial and local officials, has demonstrated its desire and willingness "to serve" in its own particular field, but to be 100 per cent effective every member should participate. What more can we do as an Association and as individual members?

As a first and practical step, let us try to face realistically the many adjustments necessary in our own group if we as nurses are to make the best possible contribution to the Peace Program. We can take pride in what the members of our profession have achieved in the war zones. Our hearts are warmed and our spirits lifted when we think of their return, for Canada needs their help to meet the new demands in the accelerated activities concerned with health.

During the war years, the civilian nurses on the home front (many of whom would have preferred to serve overseas if given the opportunity), have been called upon to assume increased responsibility, longer hours on duty, and, in addition, to assist in a variety of community activities in their leisure. hours. Both in hospitals and elsewhere, increased staff turnover, less competent auxiliary help, and shortage of doctors, only added to the strain of those conscientious nurses who have held the fort so courageously. It is also true that this group have had unprecedented opportunity for widening their individual experience and advancement in their profession.

It is realized that those nurses in the Services who have remained in Canada have not had to contend with the deprivations of active service overseas, but have accepted cheerfully the temporary curtailment of their right to choose the place and type of work they preferred, and opportunity for personal advancement in their profession has been lessened. The nurses who went overseas have, in addition, faced from the first unpredictable physical hazards, and have been subjected to discomforts, dangers

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and a way of life that will tend to make adjustment to the slower pace of civilian life somewhat difficult. The psychological reaction of those who came in contact with the tragedies, deprivations and suffering in Europe is apt to occasion impatience with civilian practices and procedures that savour of red tape and the petty attitudes that seem to be more prevalent in situations undisturbed by gunfire and bombs.

There are many adjustments to be made in the postwar world and nursing is no exception. Even before the war, the schools of nursing and the universities responsible for post-graduate courses and the education of public health nurses were unable to supply an adequate number of trained personnel to meet the demand, and the required nursing personnel for the Armed Forces has created an even greater shortage. The recent expansion of preventive medicine, allied with the anticipated necessary increase of nursing activities concerned with health insurance, not to mention the great advance that has been made in industrial nursing, means that the demand in the future for the services of the nurse will be greater than ever. There is little danger of an unemployment problem in the field of nursing for years to come.

Following is a limited outline of anticipated needs:

- 1. Plans are underway to increase both the number of hospitals and the number of beds in existing hospitals. This anticipates that not only will an increase in the number of general duty nurses be required, but also registered nurses with post-graduate training and experience in administration and supervision.
- 2. There is a shortage of fully qualified instructors in the schools of nursing and the department of the universities responsible for post-graduate courses.
- 3. Pressure groups are advocating the building and extension of convalescent hospitals as well as institutions for both young and old chronics who should be hospitalized.
 - 4. Except to the extent the Victorian Order

- of Nurses is organized nationally to meet the need, it is difficult and often financially impossible to provide nursing care in the home for persons in the low wage group.
- 5. There is need to organize the practical and undergraduate nurses, both for their own protection and that of the community they serve, which indicates a need for legislation concerned with licensing, training and supervision.
- 6. Insurance is imminent and implies an increased demand for nursing in all categories.

What special problems will the nurse, discharged from any of the three Services, have to face? War nursing, for obvious reasons, has its own special techniques, practices, methods and discipline, which differ in degree and routine from those used in peacetime institutions. A sudden change-over to duty in a civilian hospital after five years' absence will test the tolerance, understanding and patience of all concerned.

The psychological approach to the patient, the very diseases and surgical conditions encountered, differ as to variety, ratio and predominant type under war conditions. Since 1939, many changes along somewhat different lines have taken place in civilian hospitals and, if one can judge by what took place following the last war, many of the overseas nurses on discharge will feel the need for at least a period of re-orientation, and others will find satisfaction in taking a post-graduate course. As there is such urgent need for nurses in the administrative and teaching specialties every encouragement should be given the returned nurses with the necessary qualifications to take training along these lines. Their recent experience, so rich in providing an opportunity for a broader outlook and greater understanding, should be the best possible foundation on which to build future leaders in the nursing field.

There will be others who at first will not want to consider anything but a chance to relax, which will become in reality a period of re-creation of energy for the future. Still others, whose capacity for adventure has been fully satisfied, will have as their chief aim a return to the more or less routine job they had known before.

Not only has war tended to change personal attitudes and working conditions, but it has accelerated the need for many changes in the present and the future, and the field of nursing is no exception. New problems related to the maintenance and expansion of efficient nursing service throughout Canada have arisen for which a solution must be found and toward which the nursing profession has a responsibility to give leadership. Through legislation we have been granted the right to establish machinery to develop and maintain nursing

standards. Such a privilege implies definite responsibilities.

Willingness to pool our professional resources should be an aim in order that the best nursing service can be given to the greatest number most in need of it, irrespective of whether they are located in rural or urban areas. This will necessitate the closest co-operation with the departments of health and education, the medical profession, as well as the community at large, all of whom must share this responsibility if the public are to receive adequate nursing care.

It is a challenge that must be met if we are to remain true to the basic philosophy of our Association and are to play our part in the Army prepared to fight for Peace.

The Ida MacGregor Scholarships

The School of Nursing of the Royal Victoria Hospital has received a sum of \$10,000 from which an annual scholarship of \$400, to be called the Ida MacGregor Scholarship, is to be awarded. To quote the donor who wishes to remain unknown, "The gift is a tribute to a private duty nurse who held her profession in high honour, and who was intensely proud when the nurses themselves saved the School for Graduate Nurses at McGill University at a time when the University felt unable to finance it. Though in poor health herself, Miss MacGregor's

thought was ever of others. Her ways were ways of skill and gentleness, of wisdom, pleasantness and peace."

This scholarship may be used for university post-graduate study, for hospital post-graduate work, or for a travel scholarship for some one who has already had a good background of preparation and experience. If no suitable candidate presents herself two scholarships may be awarded the following year. The emphasis is to be placed on the character and nursing accomplishment of the recipient.

M. L. I. C. Nursing Service

Jacqueline Cadieux (Sacred Heart Hospital, Hull, and University of Montreal public health course) has been appointed to the Metropolitan staff in Montreal. Simonne Patry (Sacred Heart Hospital, Hull, and University of Montreal public health course) recently returned to the Montreal staff. Miss Patry went on leave of absence in June 1942 to join the R.C.A.M.C. Nursing Service. Lucille Cote (Providence Hospital, Montreal, and University of Montreal pub-

lic health course), of the Montreal staff, has resigned.

Juliette Goyer (Hotel Dieu of St. Joseph Hospital, Montreal, and University of Montreal public health course) has been transferred from Drummondville, P. Q. to Montreal. Adeste Martin (Hotel Dieu Hospital, Montreal, and University of Montreal public health course) was recently transferred from Montreal to Drummondville.

Nursing Education

Contributed by

COMMITTEE ON NURSING EDUCATION OF THE CANADIAN NURSES ASS'N.

Post-Graduate Work Available in Canada

Following two preceding articles on post-graduate courses, published in the May and June numbers of the Journal, there follows a list of post-graduate work available in Canada.

It is not claimed that this list is absolutely complete. A questionnaire was

sent to all nursing schools, and to some hospitals without schools. The response to this was very prompt and gratifying, and the list which follows is based on it. We apologize for any unintentional mistakes or omissions, and shall be glad to print corrections.

Nurses who are interested should write to the school or hospital concerned for further information.

POST-GRADUATE COURSES IN UNIVERSITIES

Name & Location of University	Courses Available	Length of Course
University of British Columbia Dept. of Nursing & Health, Vancouver.	Public health nursing. Teaching & supervision in schools of nursing.	1 academic yr. 1 academic yr.
University of Alberta, School of Nursing, Edmonton.	Public health nursing Hospital administration. Practical obstetrics (advanced). Degree course for graduate nurses.	1 yr. 2 months. 3 months. 2 yrs.
University of Manitoba, School of Nursing Education, Winnipeg.	Certificate courses in: Public health nursing Teaching & supervision School of nursing administration	10 months 9 months. 9 months.
University of Western Ontario, Faculty of Public Health, London.	Certificate courses in: Public health nursing Hospital administration. Instructor in nursing.	8 months. 8 months. 8 months.
University of Ottawa, School of Nursing, Ottawa, Ont.	Certificate courses in: Public health nursing. Nursing education & supervision Clinical course in: Ward teaching & supervision. Operating room technique. Pediatric nursing. Degree courses for graduate nurses: Public health nursing. Nursing education & supervision	1 academic yr. 1 academic yr. 4 months. 4 months. 4 months. 2 academic yrs. 2 academic yrs.
University of Toronto, School of Nursing, Toronto 5, Ont.	Graduate courses leading to a certificate: Clinical supervision. Hospital administration. Nursing education. Public health nursing. Advanced & special courses.	1 academic yr.

	Graduate courses leading to a diploma: Nursing education. Public health nursing.	2 yrs. 2 yrs.
McGill University, School for Graduate Nurses, Montreal 2, Que.	Graduate courses leading to a certificate: Teaching & supervision in schools of nursing. Public health nursing. Administration in schools of nursing (advanced). Administration & supervision in public health nursing (advanced). Administration & supervision in psychiatric nursing. Graduate courses leading to a degree in nursing: Offered in fields as listed above.	1 academic yr. 2 academic yrs.
Institut Marguerite d'Youville, 1185 rue St. Mathieu, Montreal, 25, Que.	Nursing education (B.Sc. degree). Teaching in schools of nursing (diploma). Clinical teaching (diploma). Ward supervision & administration (diploma). Organization in schools of nursing (diploma). Certificate courses as listed above for diploma.	
Laval University Quebec City	Baccalauréat en sciences hospitalières	2 yrs.

POST-GRADUATE COURSES AVAILABLE IN HOSPITAL SCHOOLS

		Annual Control of the
Name & Location of Hospital	Courses Available	Length of Course
Provincial Mental Hospital, Essondale, B.C.	Psychiatric nursing.	6 months.
Vancouver General Hospital, Vancouver, B.C.	Operating room technique. Obstetrics.	3 months. 4 months.
St. Joseph's Hospital, Victoria, B.C.	Medical technology. X-ray technology. Operating room technique. Obstetrical nursing. Surgery (O.R. technique). Obstetrics.	18 months. 12 months. 4–8 months. 4–6 months. 4 months. 4 months.
Holy Cross Hospital, Calgary, Alta	Operating technique & management.	4 months.
Royal Alexandra Hospital, Edmonton, Alta.	Operating room technique.	4 months.
Provincial Mental Hospital, Ponoka, Alta.	Psychiatric nursing.	6 months.
Winnipeg Municipal Hospitals, Winnipeg, Man.	Communicable disease (including tuberculosis if desired).	3 months.
Hamilton General Hospital, Hamilton, Ont.	Obstetrics.	14 weeks.
Ontario Hospital, London, Ont.	Psychiatric nursing (deferred affiliation).	3 months.

Strathcona Hospital for Communicable Diseases, Range Rd., Ottawa, Ont.	Communicable diseases.	3 months.
St. Michael's Hospital, Toronto, Ont.	Operating room technique & management. Obstetrical nursing.	4 months. 4 months.
Toronto Hospital for the Treatment of Tuberculosis, Weston, Ont.	Tuberculosis.	3 months.
Children's Memorial Hospital, Montreal 25, Que.	Pediatrics.	6 months.
Phillips Training School for Nur- ses, Homoeopathic Hospital, Montreal 28, Que.	X-ray technology.	1 yr.
Shriners' Hospital for Crippled Children, Montreal 25, Que.	Pediatric orthopedic nursing (de- layed affiliation).	2 months.
Royal Victoria Hospital, Montreal 2, Que.	Obstetrical nursing. Gynecological nursing. Psychiatric nursing. (see also McGill University).	4 months. 2 months. 1 yr.
Hôpital Ste.Justine, 6055 rue St. Denis, Montreal, Que.	Pediatrics.	6 months.
Verdun Protestant Hospital. P.O. Box 6034, Montreal, Que.	Psychiatric nursing (delayed affiliation).	3 months.
Ecole des Hospitalières, o.s.a. Hotel-Dieu de Québec Québec City	Operating room	9 months
Halifax Infirmary, Halifax, N.S.	Operating room technique & management. Obstetrical nursing. Radiography.	5 months. 5 months. 2 yrs.

ADDED EXPERIENCE ARRANGEMENTS IN HOSPITALS

	1	
Name & Location of Hospital	Courses Available	Length of Course
Vancouver General Hospital, Vancouver, B.C.	Arrangements are made when requested.	
St. Joseph's Hospital, Victoria, B.C	Surgical nursing. Medical nursing.	6 months. 6 months.
Calgary General Hospital, Calgary Alta.	Obstetrics. Pediatrics. Surgery.	1 yr. 1 yr. 1 yr.
St. Boniface Hospital, St. Boniface Man.	Operating room technique (as requested).	
Children's Hospital of Winnipeg, Aberdeen & Main Sts., East, Winnipeg, Man.	Pediatrics.	4 months.
Kingston General Hospital, Kingston, Ont.	Operating room.	1 month.
Hospital for Sick Children, Toronto, Ont.	Pediatrics. Operating room technique.	4 months & 6 months 3 months.
Toronto General Hospital, Toronto, Ont.	Operating room technique.	4 months.

	1	
Toronto Western Hospital, Toronto, Ont.	Operating room technique & management.	4 months.
Montreal General Hospital, Montreal 18, Que.	Operating room.	3 months.
Royal Victoria Hospital, Montreal 2, Que.	Operating room.	3–4 months.
Hôpital General Saint-Vincent de Paul, 132 King St. E., Sher- brooke, Que.	X-ray technology.	1 yr.
Shriners' Hospital for Crippled Children, Montreal, 25, Que.	Pediatric orthopedic nursing (as requested).	
Hôpital St. Luc, 32 rue Ste. Ursule Quebec City.	Clinical experience.	6 weeks.
Saint John General Hospital, Saint John, N.B.	Experience as requested in: Pediatrics. Obstetrics. Medical nursing. Surgical nursing.	
St. Joseph's School of Nursing, Hotel Dieu Hospital, Campbellton, N.B.	Obstetrics. Pediatrics. Surgical nursing. (as requested).	

A New Assistant Secretary

The President of the Canadian Nurses Association announces the appointment of Miss Winnifred Muriel Cooke as Assistant Secretary of the Association. Miss Cooke, a native of the Province of Quebec, is a graduate of The Montreal General Hospital School for Nurses and of the McGill School for Graduate Nurses where she received a certificate in teaching and supervision in schools of nursing.

Miss Cooke has been in charge of the teaching at the school of nursing in the Royal Jubilee Hospital, Victoria, B.C., the Aberdeen Hospital, New Glasgow, N.S., and the Ottawa Civic Hospital. She has been secretary of the Hospital and School of Nursing Section of the C.N.A. and has had considerable experience in local association work. Thus she comes to the National Office with

a good knowledge of nursing problems in various parts of Canada. Miss Cooke will assume her new duties on August 1, 1945.



Meyers, Montreal WINNIFRED M. COOKE

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

Provincial Association Activities

The outstanding activities of the Provincial Associations of Registered Nurses during the past months are summarized for the information of members of the Canadian Nurses Association:

Alberta Association of Registered Nurses: An experimental Placement Bureau has been established in Edmonton, in conjunction with the regional registry office, and is conducted by the regional registrar.

The director of publicity and student recruitment has received splendid cooperation from schools, the press, radio, stores, etc., and considerable interest in nursing has been evidenced by high school girls.

Eleven nurses completed the twomonths' course in administration for superintendents of small hospitals and several enquiries have already been received relative to registering for a future course.

"A Collection of Facts — Alberta Hospitals" will be available to schools of nursing and other interested persons. These data were collected by Miss Kate Brighty and are related to the history of nursing in Alberta.

Registered Nurses' Association of British Columbia: Forty-one graduate nurses completed courses in the University of British Columbia — thirtytwo, including five degree - course students, in public health nursing, and nine in teaching and supervision, including three degree-course students. Seventeen of these forty-one students received aid through the Federal Government Grant bursaries.

Four new chapters have organized during the year and the reports of districts and chapters presented to the annual meeting show increased interest in Association affairs.

In the provincial Placement Service, which is becoming more active, the problems of nurse shortage continue and increase. Married women are resigning in great numbers. The armed forces are continuing to call nurses, and and the D.V.A. hospitals are absorbing all "unattached" nurses. The few nursing sisters who return are planning to take post-graduate work before accepting positions.

Manitoba Association of Registered Nurses: An Act to provide for the training, examination, licensing and regulation of practical nurses under the provincial Department of Heatlh and Publice Welfare was assented to March 23,

1945.

A Brief was presented by the board of directors of the Manitoba Association of Registered Nurses to the board of governors, the University of Manitoba, requesting that the school of nursing education be incorporated into the University of Manitoba as a permanent faculty.

The Manitoba Student Nurses' Association was formed in November, 1944, under the sponsorship of the M.A.R.N. Monthly meetings have been held since then and the student nurses are most enthusiastic. At the time of the annual meeting, your general secretary and the editor and business manager of *The Canadian Nurse* both addressed the Manitoba Student Nurses' Association.

An amendment to Section 9 of the Manitoba Registration Act was passed in 1945, giving greater discretionary powers to the board of managers respecting the admission to membership in the Association.

New Brunswick Association of Registered Nurses: Publicity continues to be active. Posters and pamphlets were distributed through the local chapters, hospitals and by public health nurses. The trailer, "White Sentinels Guard Vital Outposts", was routed over the theatre circuits.

The library, opened last year, is proving of great interest, as is the clipping service in connection with it.

The committees on Postwar Planning and Nurse Placement Service have been merged to form one, and a survey of provincial resources and needs is being undertaken.

A group of practical nurses in one locality of New Brunswick has appealed to the N.B.A.R.N. for guidance regarding becoming licensed. They are attempting to make contact with other groups of practical nurses in the province in order to obtain better co-operation and understanding among themselves.

An institute for hospital staff nurses, under the leadership of Miss Marion Lindeburgh, director, McGill School for Graduate Nurses, is scheduled for June 6, 7 and 8.

Registered Nurses' Association of Nova Scotia: At the executive meeting held in Sydney, March 10, 1945, it was decided to send the following resolution to Dr. Davis, Minister of Public Health for Nova Scotia: "That the Association go on record as approving and urging the desirability of psychiatric

units in modern general hospitals, where a specialist is available, and in particular that such a unit be established in the new public hospital in Halifax, under construction at present."

Miss Mary Mathewson, assistant director, McGill School for Graduate Nurses, conducted a refresher course in public health nursing in February.

Miss Electa MacLennan, assistant secretary, C.N.A., visited Nova Scotia in February and interviewed many superintendents of nurses of schools of nursing regarding student enrolment. She also addressed some high school groups.

The film, "White Sentinels Guard Vital Outposts", has been shown in most of the theatres throughout Nova Scotia. Posters and pamphlets continue to be widely distributed.

Registered Nurses Association of Ontario: At the annual meeting of the Registered Nurses Association of Ontario on April 12, 13 and 14, it was recommended that the Honorable the Minister of Health be asked to withdraw the Bill to amend the Nurses' Registration Act, to include the words "Registered Assistant Nurse". The meeting felt that a study of a Practice Act covering all nursing (professional and assistant) should be made before any legislation is again submitted.

Resolutions from the General Nursing Section: "That the board of directors through the proper channels attempt to establish for nurses a priority in the purchase of uniforms, shoes and hose."

A resolution requesting that the R.N.A.O. take steps to have clinical experience in Tuberculosis Nursing made an integral part of the basic course in nursing was received from the Nurses Council on Tuberculosis Nursing following the special session on "Tuberculosis as a Community Problem" when Miss Grace M. Longhurst was the special speaker. After discussion of this resolution the following amendment was adopted: "Therefore be it resolved that the Registered Nurses Associa-

tion of Ontario should take steps to stimulate more interest in tuberculosis affiliation for general hospital students and to facilitate arrangements to accomplish it."

Registered Nurses Association of Prince Edward Island: With the money received from the Federal Government Grant, clinical supervisors have been placed in the three schools of nursing for approximately six months each. Travelling instructors in chemistry and dietetics have helped in making the instruction of nurses more general in these subjects.

A very successful refresher course in pediatrics was given by Miss M. Flander of the Children's Memorial Hospital, Montreal. Undergraduates were privileged to attend this course, too, to learn the modern care of the well child. Miss M. Lindeburgh, director, McGill School for Graduate Nurses, is conducting an institute in supervision in June.

Studies are being made of provincial Acts and of provincial registration examinations.

Registered Nurses Association of the Province of Quebec: In Quebec, as in several other provinces, married and retired nurses, together with V.A.D.'s, have done and are doing yeoman service, without which there is little doubt but that our hospitals would have been in worse than desperate circumstances.

Committees on publicity and recruitment have been active. Newspaper articles, distribution of posters and pamphlets, window displays, radio talks and conferences with high school students have constituted the programs.

Twelve district associations have been formed through an amendment of the Act.

The British system of preliminary or qualifying examinations at the end of the student's first year was put into operation in April.

Saskatchewan Registered Nurses' Association: In the Health Services Act, passed in November, 1944, provision has been made for nursing service by registered nurses under conditions set forth in the Act, and as part of the health services. A former president of the S.R.N.A. represents this Association on the Advisory Commission to the Health Services Commission.

An Instructors Institute was held in February under the direction of the travelling instructor. Refresher courses were held in March, as well as an intensive course on the epidemiology of venereal disease conducted by the Department of Health.

Plans for affiliation with the Anti-Tuberculosis League for students in approved schools of nursing in Saskatchewan are being established.

Action has been taken to include first year qualifying examinations for nurse registration.

A joint committee of representatives of the Saskatchewan Hospital Association, Saskatchewan College of Physicians and Surgeons, and the Saskatchewan Registered Nurses' Association is functioning well. It assists with the study of conditions related to nurses and nursing service, especially in hospitals.

The organization of chapters has already produced greater professional unity.

Executive Meeting

A meeting of the executive comittee of the Canadian Nurses Association was held in Montreal on May 31, June 1 and 2, 1945. Those present included: the president, Miss F. Munroe; the past president, Miss M. Lindeburgh; first vice-president, Miss R. Chittick; second vice-president, Miss E. Cryderman; honourary secretary, Miss E. Mallory; honourary treasurer, Miss M. Jenkins; chairmen of sections: Miss M. Batson, Hospital and School of Nursing; Miss H. McArthur, Public Health; Miss P. Brownell, General Nursing; convener of Committee on Nursing

Education, Miss E. K. Russell; and the following councillors: Miss B. Beattie (Alta.); Miss T. Hunter (B.C.); Miss L. Pettigrew (Man.); Miss M. Myers (N.B.); Miss R. MacDonald (N.S.); Miss J. Masten, Miss C. Livingston (Ont.); Miss D. Cox (P.E.I.); Misses E. Flanagan, W. MacLean, A. M. Robert, J. Trudel, French-speaking associate adviser (Que.); Miss M. Diederichs (Sask.); Miss M. Kerr, editor and business Manager of The Canadian Nurse; Miss G. Hall, general secretary; Miss E. MacLennan, assistant

secretary. Upon invitation: Miss E. Rogers, registrar (Alta.); Miss A. Wright, executive secretary (B.C.); Miss M. Street, executive secretary (Man.); Miss A. Law, secretary-treasurer (N.B.); Miss J. Dunning, registrar (N.S.); Miss M. Fitzgerald, secretary-treasurer (Ont.); Miss F. Upton, executive secretary (Que.); Miss K. Ellis, registrar (Sask); Miss N. Fidler, Miss W. Cooke. Upon invitation for special committee reports: Miss E. Johns, Miss E. Beith, Mrs. C. Townsend, Mother Allaire.

Annual Meeting in Manitoba

The thirty-first annual meeting of the Manitoba Association of Registered Nurses was held April 16 and 17, 1945, at the Fort Garry Hotel, Winnipeg. Two hundred and nine members registered. The president, Miss Lillian Pettigrew, presided. The officers and members of the Association were delighted to have as their guests upon this occasion, Miss Getrude Hall, general secretary of the Canadian Nurses Association, and Miss Margaret Kerr, editor of The Canadian Nurse Journal. These two distinguished guests contributed greatly to the value of the sessions.

In her presidential address, Miss Pettigrew reviewed some of the major developments of the past year and stressed the need of thoughtful planning for the future. With reference to the Practical Nurse legislation recently enacted by the Manitoba Legislature, Miss Pettigrew reminded the members that the thoughts of professional nurses should now be directed to the obligations that such legislation implies.

Miss Gertrude Hall, in her challenging address, "Bridges to the Future", stated that because of the fact that the war has brought about such amazing developments in science, in all branches of medicine, surgery, nursing education, public health and social security plans, it is our duty both as citizens and as members of the nursing profession to prepare ourselves to play a full part in extending these developments in the future.

The executive-secretary, registrar and school of nursing adviser, in presenting her reports, expressed the regret of the Association in Mrs. Marion Botsford's resignation as assistant executive secretary in July 1944. Miss Frances Waugh assumed the duties of assistant to the executive secretary and school of nursing adviser on September 15, 1944. Three members of this Association have been accepted for service abroad under the auspices of UNRRA - Misses Josephine de Brincat, Helena Reimer and Jean Petty. Two hundred and sixty-six members of the Manitoba Association of Registered Nurses are now serving in the Armed Forces. New registrants admitted to membership in the Association during the year totalled 297. Under the new schedule of Registration Examinations, adopted in November, 1944, Anatomy and Physiology is discontinued as a separate paper (this subject being now written at the end of the first year). Another feature of the new schedule is the inclusion of an examination in Surgical Specialties (Eye, Ear, Nose and Throat, Gynecology and Orthopedics), in addition to that in Surgical Nursing. With regard to the First Year Qualifying Examinations, an analysis of the results from June 1942 to the present reveals that, of 845 candidates who have written the examinations, 663 or 78.4 per cent passed on first writing, while a total of thirty-five candidates, or 4.14 per cent have been disqualified.

Miss Frances Waugh, assistance executive secretary, reported upon administration of the Government Grant fund, the student nurse recruitment program, and the organization of the Manitoba Student Nurses' Association.

On Monday evening, the members of the Manitoba Student Nurses' Association were privileged to meet Miss Hall and Miss Kerr, who spoke to them upon professional organizations and our professional Journal.

At the morning session, on April 17, reports were presented from the Graduate Nurses Associations of Brandon, Dauphin, The Pas, Flin Flon, and Selkirk; from the Public Health, General Nursing and Hospital and School of Nursing Sections; from standing committees, special committees and representatives.

The report of the Legislative Committee (convener, Miss Grace Spice) was of particular interest, as it dealt with the recently enacted amendment to the Act of the Manitoba Association of Registered Nurses, as well as with the Act to provide for the training, examination, licensing and regulation of Practical Nurses. The Placement director, Miss Olive Thomas, traced the development of the Provincial Placement Service from the time of its establishment in August, 1944. To date, there have been 4,420 office interviews and 162 applications filed by nurses. One hundred and seventy-six requests for nurses have been received. One hundred and seven nurses have been placed in positions, 51 in city hospitals, 26 in rural hospitals, 15 in sanatoria, and 15 in health agencies or industrial plants. The Placement director reported continued difficulty in procuring staff nurses for rural hospitals and sanatoria. Concluding the morning session, an informal talk was given by Mr. Phillip Dawson, executive director of the Manitoba Hospital Service Association, who outlined the development of pre-paid hospital care and medical services.

The guest speaker at the Public Health luncheon was Lieut.-Col. Charles H. A. Walton, M.D., who delivered a most informative and inspiring address on "Doctors and Nurses in Action", with particular reference to public health developments in the theatres of war.

At the opening of the afternoon session, the interesting report of the Manitoba Student Nurses' Association was given by its first president, Miss Dorothy Marshall, who outlined the aims and organization of this

newly-formed body. Miss Marshall described the activities of the various committees of the Association: music, sports, literary, dramatic and current events. Meetings have been well-attended, and have already "broadened our outlook on nursing and have made us realize that nurses everywhere have common problems", the president stated.

The guest speaker of the afternoon, Miss Margaret Kerr, in her most enjoyable and invigorating address, "Over the Editor's Desk", traced the development of the Journal during the past forty years and pointed the way to future growth and development. With carnestness, sincerity and humour, Miss Kerr made an appeal to the individual nurse to realize her responsibility in giving all-out support to her professional Journal. "Your Journal is what you make it", Miss Kerr concluded.

An excellent program, "Co-ordinated Effort", was then presented by representatives of the three Sections under the direction of the conveners, Misses Lorraine Miller, Beryl Seeman and Jean Gordon. This presentation, which consisted of a number of related projects, showed the manner in which all fields of nursing service — private duty, hospital and school of nursing, staff duty and public health — co-operate in the education of the student nurse as well as in the care of the patient, in hospital, home and community.

In addition to resolutions of appreciation and thanks, the report of the Resolutions Committee contained a resolution that the Manitoba Association of Registered Nurses request that the membership of the recently appointed provincial Tuberculosis Control Commission be enlarged to include two registered nurses.

The convention concluded with a banquet attended by one hundred and sixty-five members and guests. The banquet hall was beautifully decorated for the occasion by the Social Committee under the able convenership of Miss Kathryn McLearn. Flags of the united nations and spring flowers in red, white and blue tones provided an appropriate setting for the address of the evening. Mrs. R. F. McWilliams spoke upon the subject of UNRRA. Her address was one of absorbing interest, realism and challenge. In simple, sincere, and forthright words, the speaker painted a vivid picture of UNRRA's broad field of service, and of the need for continued and increased selfsacrifice on the part of all the people of

Canada, if the peoples of Europe are to be saved from disasters greater than those which have yet befallen them—disease and starvation.

Miss Lillian Pettigrew was re-elected president for the coming year.

MARGARET M. STREET Executive Secretary, M.A.R.N.

Annual Meeting in Ontario

The twentieth annual meeting of the Registered Nurses Association of Ontario held in Toronto, April 12-14, 1945, was opened by the president, Miss Jean I. Masten. The Association was very pleased to welcome Miss Electa MacLennan, assistant secretary, C.N.A., who brought greetings from the Canadian Nurses Association and who so willingly gave assistance on questions under discussion. Miss Eileen Flanagan, president, Registered Nurses Association of the Province of Quebec, who attended the meeting is always a welcome visitor. The president, in her address at the opening session, summarized the nursing trends and events in the life of the Association during the past year and stated the most urgent internal problem to be that of strengthening the bonds between the nine districts which together form the provincial association.

At the afternoon session on April 12 the topic "The Place of Mental Hygiene and Mental Nursing in this Reconstruction Period" was introduced by Dr. G. H. Stevenson, superintendent, Ontario Hospital, London. Other papers included: "Preparation for Psychiatric Nursing" by Hilda Bennett, University of Toronto School of Nursing; "Mental Hygiene Problems in Generalized Public Health Nursing" by Eileen Cryderman, Department of Public Health, Toronto; "Mental Hygiene and Hospital Nursing" by Mrs. Laura Fitzsimmons, nursing consultant, Committee on Psychiatric Nursing, American Psychiatric Association. A second special session was held on Friday afternoon when the subject was "Tuberculosis as a Community Problem". The principal speaker was Miss Grace M. Longhurst, director of nursing service, Mt. Morris Tuberculosis Hospital, Mt. Morris, N.Y. Following the address "Information Please" was conducted by Miss Edna L. Moore with the following authorities to answer questions: Miss Longhurst; Dr. G. C. Brink and Dr.

K. G. Shorey, Division of Tuberculosis Control, Ontario Department of Health; Dr. C. G. Shaver, superintendent, Niagara Peninsula Sanatorium; Mrs. Agnes Haygarth, director, public health nursing, Hamilton; Gladys Sharpe, director of nursing, Toronto Western Hospital. The attendance of approximately seven hundred at each of these special sessions demonstrated that this was the type of meeting the nurses wanted. The papers presented were all very interesting.

At the annual dinner, when 494 members and guests were present, Miss Edith R. Dick acting director, Nurse Registration Branch, spoke on "Experience with a Canadian General Hospital in England and France". Miss Dick's talk was extremely interesting and informative with regard to the work carried on by the nursing sisters in hospitals overseas. Due to wartime service conditions the hotel was unable to serve all who wanted to attend the dinner and many of these came in later to hear Miss Dick. Miss Beatrice Ellis, Miss A. M. Munn and Miss Janet Neilson were special guests of honour.

The business meetings of the three sections were held concurrently on Saturday morning. At the Public Health Section meeting the special speaker was Dr. C. C. Goldring, superintendent of schools for Toronto. A general session followed when the Honourable Dana Porter, Minister of Development and Planning, was the special speaker. In his timely address the Minister stressed the extent to which the government must rely upon the assistance of organized groups in instituting an effective program of post-war planning, and the responsibility which these groups, including the nursing profession, must assume, each in its own sphere.

Reports were presented at the business sessions from all standing and special committees and sections. A summary of the district reports was presented by Miss Florence H. Walker. A folio, including the report of the secretary, financial statements and the proposed budget, was prepared and given to all members who registered. The membership committee reported that the membership on December 31, 1944, was 7.024 representing apropximately 43 per cent of the nurses holding 1944 registration in Ontario. The Legislation Committee presented an amendment to the By-Laws. which was voted on by ballot and passed, whereby the annual fee for membership was increase to \$4.00 and will come into effect for the 1946 fees. The report of the Registry Adviser stated there were now twenty-one organized registries in Ontario with an enrolment of approimately 2,840 registered nurses. The Permanent Education Fund reported that six loans had been granted in 1944. Loans are available and granted to members to assist them in tak-

ing post-graduate courses. The total convention registration was 599, including fifty-three students who were representatives from thirty-four schools of nursing in Ontario. Due to the problem of hotel accommodation and available dates for conventions it was agreed that the annual meeting in 1946 should be held in Toronto on October 28-31.

The following are the officers: president, Jean I. Masten; vice-presidents, M. B. Anderson, G. Ross; section chairmen: Hospital and School of Nursing, Blanche McPhedran; Public Health, M. C. Livingston; General Nursing, Kathleen Layton; district chairmen: M. Jones, Mrs. K. Cowie, A. Scheifele, C. McCorquodale, Mrs. E. Brackenridge, I. MacMillan, W. Cooke, S. Laine, M. Spidell.

MATILDA E. FITZGERALD
Secretary-Treasurer, R.N.A.()

Annual Meeting in Alberta

The twenty-seventh annual meeting of the Alberta Association of Registered Nurses was held in the Palliser Hotel, Calgary, on March 26, 1945. Despite the one-day meeting confined to business only, the province was well represented by 127 members in attendance, many of whom came from outlying points.

After giving her presidential address, Miss Ida Johnson introduced three special guests: Miss Gertrude M. Hall, general secretary of the Canadian Nurses Association; Miss Margaret E. Kerr, editor and business manager of *The Canadian Nurse*; and Miss Elizabeth Bell Rogers, newly-appointed registrar and secretary of the Alberta Association of Registered Nurses.

Reports of Districts and Standing Committees occupied the morning session, followed by sectional meetings, election of officers and general discussion in the afternoon.

Miss Ella M. Howard, acting registrar since the retiral of Miss E. A. Pearston on February 1, 1945, reported on the progress of the Association, including courses and activities made possible by the Federal Grant. For the next three years, as an experiment, student nurses are to be allowed one week

sick leave, not cumulative, and Dominion-Provincial assistance to prospective students is to be continued for 1945-46.

Seating capacity was at a premium when Miss Gertrude Hall addressed a luncheon meeting on "The Future is Already Here". Later, Miss Margaret Kerr spoke with enthusiasm for *The Canadian Nurse*, her address bearing the title "Over the Editor's Desk".

At the Hospital and School of Nursing Section meeting, chaired by Miss Loretta Shantz in the absence of Miss Bertha von Gruenigen, it was decided that Instructors Groups in Edmonton and Calgary should study the question of adopting qualifying registration examinations at the completion of the student's first year in training as recommended at the C.N.A. Biennial Meeting in 1944, and to recommend the establishment of a school in hospital teaching and supervision at the University of Alberta. A paper on clinical supervision was presented by Miss Marion Gamsby.

Miss Betty Thorne of Calgary gave a paper on Industrial Nursing at the Public Health Section meeting, following which the group considered the feasibility of a short course or institute being given on this subject.

A discussion of salaries paid to general duty nurses occupied sessions of the General Nursing Section chaired by Miss Nancy Sewallis.

A good deal of discussion followed the reports of the Labour Relations and Legislation Committees, which it was decided to re-organize so that conveners might be is one centre.

The rehabilitation of women from the Armed Forces who might wish to enter training in approved schools of nursing in Alberta was considered in the report of the Committee on Post-war Planning, and nurse councillors are to be appointed at the rehabilitation centres to whom interested applicants may refer for information on nursing as a profession.

A report of special interest to all nurses

dealt with the study of Placement Bureaux presented by Miss Ida Johnson, following which a motion was adopted authorizing the Council to meet with District representatives at an early date in order to discuss the possibility of establishing a Placement Bureau in Alberta.

A motion to increase the annual membership fee to \$5.00 was adopted, effective January 1, 1946. Notice of motion to change By-law 16 of the Constitution relating to the election of officers will be sent to each member, to be voted upon at the next annual meeting.

Officers elected for the ensuing term are: president, Barbara Beattie; first vice-president, Helen G. McArthur; second vice-president, E. Kathleen Connor; councillor, Sister Alice Herman.

ELIZABETH B. ROGERS
Registrar & Executive Secretary, A.A.R.N.

R.C.A.M.C. Nursing Service

Matron-in-chief Dorothy I. MacRae has been promoted to the Acting rank of full Colonel. The R.C.A.M.C. Nursing Service is very proud to announce this promotion which is well merited by Miss MacRae and the honour which it brings to the Service.

Capt. (Matron) Kathleen D. Ross (Winnipeg General Hospital) is Matron of Shilo Military Hospital, Man. Capt. (Matron) Helen B. Crease (Wellesley Hospital, Toronto) is teaching instructress at Debert Military Hospital, N.S. Capt. (Matron) Bessie E. Mulvagh (Ottawa Civic Hospital) is Assistant Matron of Kingston Military Hospital. Capt. (Matron) May E. Reid (Regina Grey Nuns' Hospital) is Assistant Matron of Vancouver Military Hospital. Major (P/M) M. C. Crawford is Principal Matron of the Hospital Ship Letitia and has been replaced at Chorley Park Military Hospital by P/M Shaffner who has recently returned from overseas. Major (P/M) Rose L. King is Principal Matron in the District Medical Officers' Office in Military District No. 6, and has been replaced by (P/M) Kathleen B. Harvey at Debert Military Hospital.

The following have been awarded the R.R.C.: Capt. (Matron) Jeannette Vachon (St. Sacrement Hospital, Quebec); Capt. (Matron) Isabelle (Gillespie) Wyatt (Royal Victoria Hospital, Montreal).

The following have been awarded the A.R.R.C.: Lieut. (N/S) Elizabeth Andreas (Regina General Hospital); Lieut. (N/S Ida Burkholder (Ottawa Civic Hospital); Lieut. (N/S) Kathleen McLeod (Royal Victoria Hospital, Montreal).

The following have been mentioned in Despatches: A/Major (P/M) Evelyn A. Pepper (Ottawa Civic Hospital); Lieut. (N/S) Anna H. Craig (Royal Victoria Hospital, Montreal); Lieut. (N/S) Audrey Auger (King Edward Hospital, Bermuda); Lieut. (N/S) Margaret E. Arnold (Ottawa Civic Hospital); Lieut. (N/S) Jean T. (Hackland) Marshall (Grace Hospital, Detroit); Lieut. (N/S) Marjorie M. McCulloch (St. Boniface Hospital); Lieut. (N/S Marie Latour (St. Luke's Hospital, Montreal); Lieut. (N/S) Elizabeth M. Gordon (St. Mary's Hospital, Sault Ste. Marie); Lieut. (N/S) Alice Ecklund (Edmonton General Hospital).

Experiences at a Nursing Outpost

Editor's Note: The following are excerpts from a letter received from Alice Phillips who has been nursing with the Grenfell Medical Mission at their base hospital in St. Anthony, Newfoundland. From there she was sent on a medical trip to a nursing outpost ninety miles away and these are some of her experiences during those few weeks.

I was whisked off here in a great hurry, in answer to many emergency calls and expected to stay only a few days. It is now exactly three weeks and I am still terribly busy. Little did I know what was ahead or would I ever have tackled it? I really didn't have much choice. Two days had been spent in getting together suitable clothes, medical supplies, etc. They sent a dog-team for me from Canada Bay and we left bright and early the next morning. The trip was a marvellous experience. I had expected to freeze as one nearly always does on a dog-team, but I guess the warm dickie outfit which I wore was adequate. I enjoyed it immensely. We had eleven dogs and two men, the komatik box and me (quite a load!) A komatik is the type of dog-sled used here. The going was good, as there was not too much snow and we covered a good sixty miles with the temperature registering -10 degrees. We stopped at a woodsman's cabin for a warmup and tea half way, then camped the night in Mainbrook. We lodged in a cabin



Assembling the dog-teams.

where our quarters were small and crowded but the friendly people fed us and soon I was sleeping soundly on a feather bed which I shared with the lady of the house. We rose early to a breakfast of bread and tea. After travelling about fifteen miles we made camp, had coffee, soup, corned beef and chocolates. (As the men told me, "To keep your blood warm, Miss".)

Well, it was fun and the men were good to me and I began to think what a wonderful life this was. We travelled on into starlight with a full bright moon shining down on us through the trees, and finally arrived at our destination at 8 p.m. On the outskirts of the village I had to stop off to see a sick woman who was seven months pregnant and very ill. After an examination I decided to leave her till morning and proceeded to where I was to stay.

To explain matters a bit, there is a nursing station here which closed down last October when the nurse left. The people have been without medical care for several months and there are few supplies at my disposal. I am using the dispensary at the station which is a few minutes walk from the house.

I was no sooner settled, fed, introduced and in bed, than a knock came to the door. They wanted me for the "woman" right away. I got up, dressed and taking with me my maternity bag I proceeded to walk the long cold three miles back to the house we had just passed. I shall never forget the feeling I had at being dragged out of my bed that morning at three o'clock and into a howling blizzard. That was when I began to think of my kind friends' advice before I left for this country and began to realize that I was in for it at last! Nevertheless, it was exciting.

We reached the tiny shack to find conditions much the same as I had left them so I decided to stay the night.

There were three rooms in the housethe patient in one, three children in the other, the husband, myself and the chickens in the kitchen. I got a little sleep to be awakened in an hour or two to the tune of the rooster crowing and to the realization of the tasks that confronted me. My patient had slept on her hypodermic of morphine, her first sleep for three weeks. I gave her morning care, fed and bathed her, and left instructions with a neighbour as to her diet, etc. Later I took her to hospital where it was found she had cancer of the cervix and was unable to deliver herself.

I left for home after a breakfast of the eternal bread and tea. It was a beautiful sunny morning as I walked back over the ice and I saw something of this new part of the country. I watched the sun rise above the snow-capped hills and as it shimmered on the fresh snow I felt rejuvenated in spirit and ready to tackle whatever came.

I arrived home to a sea of aches and pains, cuts and infections, and people calling me from every doorway. With a scant supply of sterile dressings and bandages, I soon began to get uneasy. Most of the wounds were old, infected and neglected, and never before had I to make so many decisions by myself so hastily. The people took my word as gospel truth and in return expected me to have a direct cure and answer for all their "wonderful" aches and pains. The work became so heavy it was necessary to open the nursing station which made things a lot easier, with a girl to help keep up supplies. For the first few nights I was called every night; then things quieted down until a call came from a place ten miles away.

We arrived in two hours by dog-team. My patient was a boy of sixteen suffering severely from a long standing infection from impetigo and running a temperature of 104 degrees. I showed his mother how to put starch poultices on and left some ammoniated mercury ointment with her to apply when the

crusts were removed. A week later I visited him and found him almost cured. It is cases like these which give impetus to our work up here.

Everyone in the village wanted to see "the nurse", but I had a feeling I should get back to my station that night. Sure enough I was no sooner in bed at midnight than a call came to a "woman in fits". How I dashed! I pulled on my ski pants over my pyjamas, grabbed my bag and followed the man to their home where I found a woman in an eclamptic convulsion. I learned she had been taking convulsions for twenty-four hours. I wired to the doctor at St. Anthony who rushed up some intravenous glucose and she did well for a few days. However, her family believed in faith healing and, the crisis passed, they ceased to co-operate. With all my tact and patience (what little was left) I tried to persuade them to send her to hospital by plane but all to no avail. Later she died and I felt very dispirited knowing she might have been saved. That is one of our many problems here.

Eventually the work was somewhat under control, and with four of the sickest patients I started our long trek back to St. Anthony. The night before I had been called to a maternity case, the fifteenth on my own but my first in a home. After two and a half hours the mother was delivered a boy weighing eight and a half pounds, and all was well. Almost immediately, I was called to see a woman with an apparent acute appendix whom I watched for the rest of the night. I decided she would have to go to hospital, and we got her off at 4.30 in the morning by dog-team. By ten o'clock our other three teams were on the trail despite the storm which was brewing. I had packed the patients in their coach-boxes well wrapped in blankets and quilts with hot irons to their feet. Crossing the barrens the dogs sunk in the snow up to their ears but there was no turning back. We crawled along at four miles an hour and I thought of the ninety miles ahead! The poor drivers worked as hard as the dogs and in some cases pulled the komatiks themselves.

After the first six or seven miles the men were nearly exhausted so we stopped to "boil a kettle", which is done on top of the firm snow. The warm tea tasted good to everyone and we also ate a snack of lunch. The next ten miles were even worse than the first and my patients were none too well. The wind started to blow, it was snowing and breaking the trail was no picnic. In some places the driver had to go ahead on snowshoes to lead the dogs. At one point we lost the trail and knew ourselves to be miles from Mainbrook where we were to spend the night. At last it stopped snowing, the sky cleared, and we had the most gorgeous moonlight night. The full moon and bright stars shining down on the thick forest, laden heavy with fresh snow, was a picture of rare value.

At 3 a.m. we caught our first glimpse of a light. We had reached Mainbrook! Kind friends took us in and we unloaded the patients one by one from their komatiks to improvised beds. After several hours I had them comfortable and was settling to some rest myself when a knock came to the door and a team drew up. It turned out to be the patient who had left six hours ahead of us! Poor woman! During the storm they had lost their way and after making camp had waited for daylight. Apparently they had heard our dogs as they went by, followed the sound, and found the trail. The patient was badly shaken up but otherwise her condition was much the same. We rested all that day and the night and felt much better. A start was made early next morning to continue the last sixty miles of our trip to St. Anthony.

It was much better going, with the snow not so deep and we drove across the frozen bays nearly all the way. I now had lots of time to think, and wondered what it was that had brought me so far to this strange country and strange

people; but I realized with satisfaction that this was the type of work I had longed to do and was at last fulfilling my cherished dream of "backwoods nursing".

Finally we got onto the home stretch and at midnight our hearts leaped for joy as we dashed down the last "fox farm hill" leading into St. Anthony. We awakened the whole staff as we drew up to the front door of the hospital. The nurses and aides helped me get the patients to bed. The cook got up and made us a hot lunch. The doctor greeted me warmly and the load of responsibility fell from me for the first time in three weeks. It was good to be back again, but I am looking forward to making another trip and staying all summer, just as soon as navigation opens in June.

I had numerous other cases in Canada Bay, answering calls to all parts of the surrounding country. Living conditions are poor and yet the people amazingly contented. A lot of my time was spent in teaching diet and general health measures. Beri-beri exists here still from lack of foods containing vitamin B. There is much scope for public health, dietetics and agriculture, besides general medical aid. All this makes me appreciate more than ever the standard of our nursing service in Canada.

It is a great life, and I love the scope and breadth of our work. I wish you could try it for yourself some day; you'd feel the same!

The Riboflavin Content of Milk

Reports on the quantity of riboflavin in milk vary according to a number of biological assays, but consumers can rest assured that pasteurization does not destroy the riboflavin content to any appreciable extent. Actual riboflavin content of milk is said to be controlled by the breed of cow and by seasonal variations. It is said to be higher in summer than in winter; highest in Jersey cows, medium in Holsteins, and lowest in Guernseys and Ayrshires.

STUDENT NURSES PAGE

Reflections on an Afternoon at Baby Clinic

MARY BOYD
Student Nurse

School of Nursing, Victoria Public Hospital, Fredericton, N.B.

One of the many jobs of the Victorian Order of Nurses is the holding of a weekly well-baby clinic. I attended clinic on two afternoons in April — warm Spring days when babies were brought from far and near.

Babies are brought to clinic every week for the first six months and every two weeks thereafter. It is surprising the number of older children who come, boys and girls three and four years old. I, of course, was very interested in our own babies—babies that we had had in our case room and nursery. It is interesting to note the difference in babies after six months or a year. They all had had exactly the same start in the nursery but were sent home to vastly different environments.

There were three women in whom I became especially interested. They, at one time, belonged to an Opportunity Class (for backward children) and now two of them are doing a fine job at being mothers, while the third appears undernourished, unkempt, and dirty, and the baby is in the same condition. I was also interested to see scatter-brained girls, whom I knew in high school, making perfect mothers, discussing teeth, formulas, etc.

One other person interested me very much. She is a young English war bride, and told of her experiences while crossing the Atlantic, when she found herself in a very small cabin in a very crowded ship, along with seven other mothers and six babies besides her own. In the midst of this confusion she had gone to other parts of the boat to look after seasick, frightened older children.

But to get back to the clinic itself. It is here the mother brings all her problems-things that seem too unimportant to take to the family doctor teething troubles, diet, stool, rashes, etc. Babies are weighed every week, and measured about once a month. Protruding navels are strapped down, tight foreskins are pushed back, and mouths are examined for tied tongues. Mothers are advised in regard to starting babies on nutrim, pablum, orange juice, white fish, egg volk, vegetables, etc. The nurse also advises her when to have the child inoculated for whooping cough and diphtheria. Each baby has a card on which is recorded the weekly weight and measurement and any remarks such as "foreskin retracted." The nurse keeps a chart with the weight and measurement and anything of interest since the last weekly visit is recorded. She works in perfect harmony with the doctors of the city and is familiar with their preferences regarding new foods in the diet, etc.

The nurse showed me an emergency pack, which they were advised to have ready at the beginning of the war. It

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includes all the articles necessary for a home delivery.

If you think babies are uninteresting

go down and visit the well-baby clinic for a little while some afternoon. You will find it a few hours well spent.

A New Affiliation

Arrangements have been completed whereby an affiliation has been established between schools of nursing in Saskatchewan and the Saskatchewan Anti-Tuberculosis League. A teaching department has been set up at the Fort Qu'Appelle Sanatorium at Fort San, Saskatchewan. Early in June the first class of sixteen students was welcomed to the sanatorium.

The major objectives of the eightweek course are to prepare the student to recognize the opportunities for the prevention and control of tuberculosis and to give her an appreciation of the treatment and nursing care of the tubercular patient. Thus, as a graduate nurse, she will be able to apply the principles she has learned regardless of what field of nursing she chooses.

A great deal of credit is due to the League officials for making this course possible to the superintendents of nurses who recognize its value and have rearranged educational programs so as to give their students the benefit of such a course; also to the Saskatchewan Registered Nurses Association for its enthusiastic support.

Manitoba Student Nurses' Association

The members enjoyed hearing Margaret Kerr, editor of *The Canadian Nurse*, and Gertrude Hall, general secretary of the C.N.A., at the monthly meeting in April. There was so much interest in the editor's talk that each school is sponsoring a drive among the student nurses for the purchase of the *Journal*.

Approximately two hundred members enjoyed the performance of "The Question of Figures", a play staged by members of the St. Boniface Hospital Student Dramatic Club. This was the opening number of the

Association's May meeting when the constitution of the Association was adopted and the drawing of the prizes for the raffle was done by Frances Waugh, assistant executive secretary of the M.A.R.N. The meeting closed with election speeches for officers for 1945-46, the results being as follows: president, L. McDonald, St. Boniface Hospital; vice-presidents, S. Bickwell, Grace Hospital; H. McGavin, Winnipeg General Hospital; P. Scott, St. B. H.; treasurer, I. Stuart, St. B. H.; recording secretary, A. McBain, St. B. H.; corresponding secretary, J. Simpson, W.G.H.

Book Reviews

Patients have Families, by Henry B. Richardson, M.D., F.A.C.P., Associate

Professor of Clinical Medicine, Cornell University Medical College. 408 pages.

What is Acid-Moisture ?



Dermatitis in infants brought about by wet diapers, clothes and bed clothes is a common and troublesome condition. Because of it the busy physician is often faced with questions from anxious mothers. While normally acid because of uric acid content (C₅H₄N₄O₃), urine is sometimes converted into an alkaline irritant in the "ammoniacal diaper" by urea-formed ammonia (NH₃).

On the basis of simple mechanical protection, the use of Z.B.T. Baby Powder

with olive oil helps to resist moisture dermatitis. Z.B.T. clings and covers like a protective film—lessens friction and chafing of wet diapers and shirts. The mechanical moisture-resisting property of Z.B.T. may be clearly demonstrated. Smooth Z.B.T. on the back of your hand. Sprinkle with water or other liquid of higher or lower pH. Notice how Z.B.T. Baby Powder keeps skin dry as the drops roll off. Compare with any other baby powder.

Z.B.T.—the only baby powder made with olive oil

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Published by The Commonwealth Fund, 41 East 57th St., New York City 22. Price \$3.00.

Reviewed by Electa MacLennan, Assistant Secretary, Canadian Nurses Association.

Under the auspices of the faculties of public health, medicine and psychiatry of Cornell Medical College, a group of eminent specialists in public health, preventive medicine, nursing, social work and psychiatry, have undertaken a unique research in co-operative thinking about illness in families. "Patients have families" is the first presentation of the findings of this study. Although Dr. Richardson addresses his book to the medical profession, there is much for public health nurses and case workers. The book is written, for the most part, in an easy readable style, but the author uses highly technical phrases and at times seems to get lost in the jargon of his specialty.

The purpose of "Patients have families" is to present "(a) the value to the medical profession of seeing the patient as a personality and as part of his family constellation, and (b) the essential contribution which can be made by psychiatry and the 'social disciplines' (i.e. professions) to this view of the patient and to treatment plans geared to such an emphasis".

In the introduction the author clarifies the area of interest covered by the study, of which this book is but the initial report, thus: "The profession of medicine progressed from the diseased organ to the total personality of the patient and is now ready for the concept of the individual as a member of a family in its community setting . . . other professions think of the family unit as naturally as a doctor thinks of a patient ... Some nursing services also start with the family in the community and proceed . . . from family health to individual health to sickness . . . The time is now ripe for a co-ordinated attack on the problems of family adjustment in relation to the maintenance of health and the treatment of illness".

"Patients have families: hospitals have patients: therefore the hospital has something to do with the family". Thus does the author introduce his readers to the problem undertaken by the study group to prove and support this apparently self-evident syllogism. In Parts 1 and 2, through the medium of case history analyses, we are shown "The Family as a Unit of Illness" and "The Family as a Unit of Treatment". These analyses show that hospital case histories are oriented to the search for a diagnosis and, over a period of more than five years, case histories reveal only individual diagnoses and say nothing about the family. Thus, though hospitals have patients and patients have families, the conclusion that hospitals have something to do with the families could not be established in the discussion of "The Family as a Unit of Treatment". The interrelationship of the work of the physician, psychiatrist, case worker and public health nurse is clearly set forth in these chapters.

The presentation of the part of the public health nurse in the treatment of the family as a unit is set forth in excellent fashion. "The public health nurse . . . in addition to her remedial activities is interested in prevention in a direct sense: in maintaining family equilibrium before it has a chance to break down", and, if I may be permitted one more quotation: "The public health nurse bears a resemblance to the doctor in her interest in medicine: to the bedside nurse in her basic training; to the medical social worker in her knowledge of the community and its medical resources; to the family case worker in having a base in the community and an interest in the family as a fundamental unit of practice. The condition which is constant for all of these is her interest in prevention, through which she gets into action earlier than the others, often before the disturbances of the family equilibrium have taken the form of illness".

In Part 3, "Present and Future", the author touches briefly on the stresses and strains, emotional as well as physical, which the war has placed upon our family structure causing a disturbing break-up of the family as a unit. This report is concluded with a short discussion on "The Family Unit as a Subject of Research", in which the author depicts the techniques adopted in conducting this "family study". The book is carefully and fully documented throughout. In the extensive appendices we find



examples of the professional techniques used by the Committee, the lay-out of the Study, and a glossary of psychiatric terms. These appendices are of considerable value in making this book a real and useful contribution to the literature of family studies.

Cheating Your Children, by S. R. Laycock, Ph.D., and Alan Brown, M.D., F.R.C.P. 36 pages. Published by The National Committee for Mental Hygiene (Canada), 111 St. George St., Toronto 5. 1945. Price 15 cents.

Dr. Laycock and Dr. Brown presented this series of nine talks on the School for Parents conducted by the Canadian Broadcasting Corporation. They are written in the language of the layman with copious case illustrations and would make an excellent addition to the child health conference library shelf. The topics covered include cheating the child of love, independence, success, approval, self-esteem, friends, clear minds, good characters and good bodies.

The Control of Communicable Diseases, an official report of the American Public Health Association, published under their auspices at 1790 Broadway New York 19. 146 pages. 6th Ed. 1945. Price 35 cents; special rates for large numbers of copies. French translation available.

First published in 1916, this handbook has been fully revised and brought into line with present-day knowledge of the wide range of communicable diseases. Each disease is briefly described with regard to its clinical and laboratory recognition, the etiologic agent, the source of infection, the mode of transmission, the incubation period, the period of communicability, susceptibility and immunity, prevalence and methods of control. A concise, useful text for every nurse to own.

The Attendant's Guide, by Edith M. Stern, in collaboration with Mary E. Corcoran, R.N., psychiatric nursing adviser, U. S. Public Health Service.



104 pages. Published by The Commonwealth Fund, 41 East 57th St., New York 22. 1945. Price 50 cents; special rates for large numbers of copies.

With mental hospitals employing more attendants than ever before in their history, a comprehensive outline of their functions and duties makes a useful addition to the growing list of available material for aides. Hospitals which provide a course for attendants will find this publication useful as a reference text. For those institutions where no particular instruction is given, "The Attendant's Guide" presents a clear picture of desirable practices.

REGISTERED NURSES' ASSOCIATION OF BRITISH COLUMBIA

(Incorporated)

An examination for the title and certificate of Registered Nurse of British Columbia will be held September 11, 12 and 13, 1945.

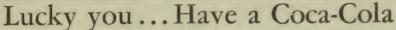
Names of Candidates for this examination must be in the office of the Registrar not later than August 11, 1945.

Full particulars may be obtained from: ALICE L. WRIGHT, R.N., Registrar 1014 Vancouver Block, Vancouver, B.C.

Part 1 outlines the general routines of hospital care. Instructions regarding ward housekeeping, ventilation, personal hygiene of the patients, clothing care. meal-time routines, exercise, etc., are given with simple, practical suggestions which may make for a much better ward atmosphere. Part 2 describes the various types of personalities the attendant will encounter. The wise advice on the handling of disturbed individuals will make for much smoother service. "Nobody likes being pawed, so keep your hands off patients. Never show annoyance, surprise or disgust . . . Explain what you are doing and why, and praise improvement ... Invalids, physical or mental, are not punished; they are treated". Part 3 discusses the future for attendants in this type of work.

Asepsis in Communicable-Disease Nursing, by Ella Hasenjaeger, R.N., M.A. 182 pages, 27 illustrations. Published by the J. B. Lippincott Company: Canadian office: Medical Arts Bldg... Montreal 25. 2nd Ed. 1944. Price \$2.00. Every step in the establishment of adequate technique in the care of patients having a communicable disease is carefully described. To make learning more positive, there are excellent posed illustrations. Part 1 outlines the principles of medical asepsis - to limit the infecting micro-organisms to a small area; to limit infectious material to the fewest possible number of articles; to prevent contact infection, etc. Detailed instructions applicable to every type of infectious nursing care are outlined. A section on the application of these rules to army hospitals is included. Part 2 will be especially useful to instructors and ward teachers as the various methods of instruction are discussed and illustrated. There is an extensive reference bibliography designed to encourage broader reading on the numerous aspects of aseptic care.

How Shall I Tell my Child, by Belle S. Mooney, M.D. 192 pages. Published by Longmans, Green & Co., 215 Victoria St., Toronto 1. 1944. Price \$2.50. Sub-titled, "A Parents' Guide to Sex Education for Children", this book is valuable for its simplicity, clarity and commonsense. The whole problem of who





WANTED

Applications are invited immediately for Staff positions with the Department of Public Health and Welfare, Halifax, Nova Scotia. Apply, stating qualifications, in care of:

Supervisor of Nurses, Department of Public Health & Welfare, c/o Dalhousie Clinic Bldg., Halifax, N.S.

should give the instruction is discussed. Dr. Mooney places the responsibility squarely where it belongs "on the parents' shoulders". She recognizes that the reason so many parents shirk their teaching responsibility is because they find their own knowledge of facts and vocabulary either hopelessly immature or so crusted over with taboos they shrink from bringing the information

out into the open. In an understanding fashion, Dr. Mooney advises parents how to answer the questions their children ask. She goes further and answers a host of questions which parents themselves have asked her. To solve the problem of when to start sex education, parents are advised "to think less in terms of age and number of birthdays and more in terms of individual capacities".

Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers and resignations from the Victorian Order of Nurses for Canada:

The following nurses, who have been on leave of absence with scholarships from the Victorian Order of Nurses for Canada, hav-

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For further information apply to:

Miss Caroline Barrett, R.N., Supervisor of the Women's Pavilion, Royal Victoria Hospital, Montreal, P. Q.

Miss F. Munroe, R. N., Superiutendent of Nurses, Royal Victoria Hospital, Montreal, P. O.

ing completed their course in public health nursing at the University of Toronto have been posted as follows: Doris Small, Owen Sound, Ontario; Vivian Dodd, Napanee, Ontario; Margaret McPherson, Walkerton, Ontario; Elizabeth Hicks, Porcupine, Ontario

The following nurses have been appointed to the Toronto staff: Lola Pearsall (St. Paul's Hospital, Saskatoon, and public health course, University of Toronto); Dorothy Rogers and Isabel Oliver (Victoria Hospital, London; B.Sc.N. University of Western Ontario).

The following nurses have been appointed to the London staff: Margaret Bain (St. Joseph's Hospital, London, and public health course, University of Western Ontario); Jean Burgoin (Victoria Hospital, London, and public health course, University of Western Ontario); Ruth Burston (Royal Victoria Hospital, Montreal, and public health course, University of Western Ontario).

The following nurses have been appointed to the York Township Branch: Ruth M. Kidd (Victoria Hospital, London, and public health course, University of Western Ontario); Joy Robinson (University of Toronto School of Nursing).

Mary McLean (St. Joseph's Hospital, Victoria, and public health course, University of British Columbia) has been appointed to the Kingston staff.

Grace Grant (Hospital for Sick Children, Toronto, and public health course, University of Toronto) has been appointed to the Timmins staff.

Mildred Williams (Royal Jubilee Hospital, Victoria, and public health course, University of British Columbia) has been appointed to the Victoria staff.

Nancy Bolton (Vancouver General Hospital, and public health course, University of British Columbia) has been appointed to the Surrey staff.

Helen Furlong has been transferred from the Peterborough to the Ottawa staff. Florence Goward has been transferred from the Vancouver to the West Vancouver staff.

Margaret Graham, from the Saskatoon staff, and Kathleen Tapp, from the West Vancouver staff, have resigned to be married. Norma Beckett has resigned from the Winnipeg staff. Kathlyn MacDonnell has resigned from the East York staff.

Obituaries

Mary Florence Galbraith died recently in Toronto. Miss Galbraith was a graduate of the Toronto General Hospital and a member of the Class of 1906. She was engaged in private duty for some time, then joined the Toronto staff of School Nurses. She held this position until 1915, when she joined the No. 4 Canadian Hospital Unit. While overseas she served in France, Malta, Greece, England and on hospital ships.

Margaret D. Kelman, who more than fifty years ago graduated from the General and Marine Hospital, St. Catharines, and St. Michael's Hospital, Toronto, died recently in Toronto. For many years she was superintendent of the hospital in North Bay founded by the Victorian Order of Nurses. Later, for twenty-five years, she was on the staff of the St. Elizabeth Visiting Nurses' Association, Toronto.

Mrs. A. H. King (Annie Orr) died recently. Mrs. King was a graduate of St. Luke's Hospital, Ottawa, and a member of the Class of 1920.

NEWS NOTES

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Gena Bamforth, 54 The Oaks, Bain Ave., Toronto

DISTRICTS 2 AND 3

BRANTFORD:

Members of Districts 2 and 3, R.N.A.O., met recently at the Brantford General Hospital with Kathleen Cowie, chairman, presiding. The invocation was given by the



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CLINICAL PROCEDURES & THEIR BACKGROUND

By Agnes E. Pavey, Examiner to the General Nursing Council for England and Wales. A new English textbook for senior nursing students. It shows the significance for clinical work of the findings of pathologist and bacteriologist. It discusses: thoracic radiography, blood grouping and transfusions, x-ray and radium therapy, shock therapy, etc. 331 pages. 43 illustrations. \$3.00.

THE RYERSON PRESS
TORONTO

Rev. H. W. Mollins and greetings from the medical staff were extended by Dr. D. G. Twiss. An interesting report of the activities of the Districts was presented by Marie Felpush. Mr. George Goodfellow addressed the gathering on war conditions in England. At supper, served by the B.G.H. Alumnae Association, Dr. A. Overholt told the members of the work of the nursing sisters in Italy. Florence Walker, associate secretary of the R.N.A.O., gave a brief talk on the work of the organization. Piano and vocal solos were rendered by Shirley Campbell and Elizabeth Russell, student nurses.

Elizabeth Russell, student nurses.

An impressive Vesper Service was held in May in Central Presbyterian Church, Brantford. The Rev. J. Kelman addressed the nurses and anthems were sung by a choir of student nurses. Mrs. R. Hamilton

rendered a vocal solo.

Brantford General Hospital:

At a well attended meeting of the Alumnae Association Dr. C. R. Rudolph spoke on anesthesia and Mr. T. A. Staples, Dominion Oxygen Company, gave an informative address on oxygen therapy and showed pictures illustrating the administration of oxygen.

DISTRICT 8

OTTAWA:

At a recent meeting of District 8, R.N. A.O., seventy members were present. The session opened with a few words of thanksgiving for the end of hostilities in Europe. Mrs. Stewart, representative to the Wartime Prices and Trade Board, reported on the shortage of uniforms, hose and shoes, and it was decided that a higher priority for these articles for nurses be forwarded to the Administrator of the W.P.T.B. Complaints were voiced as to the finishing of garments. The report of The Canadian Nurse circulation, presented by Evelyn Shiels, showed that twenty-three new subscriptions and four renewals had been received. Several have taken advantage of the new offer of three years for \$5.00. Reports of the R.N.A.O. convention were presented by W. Cooke, C. Livingston, and Miss Sabourin. Miss Landon was appointed to the executive as representative to the General Nursing Section.

Dr. J. E. Plunkett gave an informative address on "The Cardiac Patient". Slides served to emphasize the main points in this discussion. Hazel Latimer moved a vote of thanks to Dr. Plunkett.

Ottawa Civic Hospital:

The following nurses from the O.C.H. recently attended a refresher course in teaching and supervision in Toronto: G. Ferguson, H. Tanner, D. Johnson, D. Grieve, M. MacFarlane, L. Patterson, K. Dooley.

QUEBEC

MONTREAL:

Children's Memorial Hospital:

Dora Parry, superintendent of nurses, spent a short period of observation at the Children's Hospital in Boston during the latter part of April. Recent additions to the staff are: Anne H. Dubé (Hôpital Ste. Jeanne D'Arc, Montreal); Jean MacDougall (Royal Jubilee Hospital, Victoria). Jessie Watt and Phyllis Bierling have resigned.

St. Mary's Hospital:

The St. Mary's Hospital School for Nurses Alumnae Association recently entertained the 1945 graduating class at a dinner. T. De-Witt, C. Lewis, D. Sullivan and Mrs. T. Cherry were in charge of arrangements.

Adela Marwan, who resigned recently from the operating room staff, has returned

Adela Marwan, who resigned recently from the operating room staff, has returned to us as supervisor of the medical wing, 2nd floor. She replaces Joan Tallon who will spend the next few months in Cornwall.

SASKATCHEWAN

HUMBOLDT CHAPTER:

This Chapter reports a three-day refresher course given by Grace Giles, travelling instructor, which was attended by the Reverend Sisters and married nurses in the district.

REGINA CHAPTER:

Mrs. Mary E. McNeill (McKenzie) has resigned as registrar of the Regina Chapter. Mrs. Margaret Stark (Kahlo), her successor, is already known for her contributions in the past to professional activities in the province. Eleanor Worobetz, president of the Regina Chapter, is congratulated on the recognition recently bestowed upon her brother, Capt. Stephen Worobetz, M.C., for distinguished services rendered in action in Italy.

Saskatoon City Hospital:

Fifty graduates from the Saskatoon City Hospital recently met in the Hotel Georgia, Vancouver, for a reunion. Classes from 1930 to 1944 were represented and members came from various centres throughout the province.

Colour experts have found that paints of green and blue shades tend to avert nausea of passengers when applied to the interior of airplanes, while yellows and browns tend to increase the unpleasantness.



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Vancouver General Hospital desires applications from Registered Nurses for General Duty. State in first letter date of graduation, experience, references, etc., and when services would be available. Eight-hour day and six-day week. Salary: \$95 per month, living out, plus \$19.92 cost of living bonus, plus laundry. One and one-half days sick leave per month accumulative with pay. One month vacation each year with pay. Note: The Hospital can obtain exemption for accommodation from Emergency Shelter Administration. The nurse is not exempt, excepting through employ of Hospital. Apply to:

Miss E. M. Palliser, Director of Nurses, Vancouver General Hospital, Vancouver, B. C.

WANTED

General Duty Nurses, registered or graduates, are required for the Lady Minto Hospital. The salary is \$90 and \$80 per month, with full maintenance. Apply, stating full particulars of qualifications, to: Lady Minto Hospital, Cochrane, Ont.

WANTED

Applications are invited immediately for the positions of Science Instructor and Nursing Arts Instructor for a School of Nursing of 150 students in a 335bed hospital in Alberta. Apply, stating qualifications and salary expected, in care of:

Box 7, The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P.Q.

WANTED

A permanent position is available for a General Duty Nurse in a modern 37-bed hospital. Salary, \$100 per month; 8-hour day. For more information write or wire to:

Superintendent, Flin Flon General Hospital, Flin Flon, Man.

WANTED

Two experienced Operating Room Nurses are required. General Staff Nurses are also wanted for day and night duty. 8-hour day; 6-day week. Apply to:

Superintendent of Nurses, Toronto Hospital for Tuberculosis, Weston, Ont.

WANTED

Registered Nurses are required immediately for General Duty in Ex-Servicemen's Pavilion. Nurses are also required for Operating Room and Ob-stetrical Unit. Salaries depending upon experience. Full maintenance living out. Railway fare to Edmonton refunded after six months' service. Apply, stating experience, to:

Superintendent of Nurses, University Hospital, Edmonton, Alta.

WANTED

A Registered Nurse is required as Night Supervisor; three Registered nurses are also required for General Staff Duty. Eight-hour day and six-day week, with full maintenance. Apply, stating salary expected, to:

Superintendent, Shriners' Hospitals for Crippled Children, Montreal Unit, Montreal 25, P. Q.

Vol. 41, No. 7

WANTED

A Senior Instructor of Nurses is required for a Training School of 60 pupils. Salary, \$135 per month. Apply, stating qualifications, age, religion, etc., to:

Superintendent, Glace Bay General Hospital, Glace Bay, N.S.

WANTED

A Tuberculosis Unit Supervisor is required for a Tuberculosis Unit of 48 beds. Salary, \$105 per month; 8-hour day; 6-day week. Apply, stating qualifications, age, religion, etc., to:

Superintendent, Glace Bay General Hospital, Glace Bay, N.S.

WANTED

A qualified Instructress is required immediately for a 120-bed hospital. Apply, stating qualifications, experience, and salary expected, to:

Superintendent, General & Marine Hospital, Owen Sound, Ont.

WANTED

A Lady Superintendent and two nurses are required for the Barrie Memorial Hospital in Ormstown. For full particulars write to:

The Medical Superintendent, Barrie Memorial Hospital, Ormstown, P.Q.

WANTED

An Assistant to the Superintendent of Nurses is required by the Sherbrooke Hospital. Applicants must also be able to assist with the instruction for a rapidly-expanding English School of Nursing. Position available immediately. Apply, stating qualifications, experience, and salary expected, to:

Superintendent of Nurses, Sherbrooke Hospital, Sherbrooke, P. Q.

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Miss M. L. Buchanan, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P. Q.

WANTED

A qualified Dietitian is required for a 117-bed General Hospital. Apply to:

Superintendent, St. Joseph's Hospital, Peterborough, Ont.

JULY; 1945

Official Directory

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- Saskatchewan Registered Nurses Ass'n: Miss Kathleen W. Ellis, 104 Saskatchewan Hall, University of Saskatchewan, Saskatoon.

OVOLUME 41 NUMBER 8

> A U G U S T 1 9 4 5

CANADIAN NURSE





Lazy Days in Midsummer

Photo by N/S B. Jenkins

See page 584



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FATHERS OF CANADIAN MEDICINE





Abraham Gesner M.D., 1797-1864

ABRAHAM GESNER is one of the best known of the early physicans of Nova Scotia. He studied surgery and medicine in England under Abernethy and Astley Cooper, returning to his native place, *Cornwallis, to practise his profession. Because of his genial and generous nature, his popularity was widespread.

Abraham Gesner was a man of medium height, with deep chest and square shoulders. His eyes reflected his charming personality and his black hair never changed colour throughout his lifetime. He was devoted to scientific pursuits, geology being one of his main interests. While traversing the country making professional calls, he invariably would pick up specimens for his collection. Music was a delight to him and he played both the flute and violin. He married at the age of 28 and had eleven children.

In 1838 Gesner was appointed Provincial

Geologist of the Province of New Brunswick. During his scientific inspection of that province, he collected valuable and interesting specimens of minerals, plants and bird and animal life. His exhibit is now housed in the museum of Saint John City and is valued to this day. A number 4 of books dealing with his scientific discoveries were written and published by Gesner. In 1854 he patented, in the United States, his discovery of coal oil under the name of Keroselene. This name was afterwards shortened to Kerosene.

A year before his death, Gesner was offered the Chair of Natural History in Dalhousie College. Despite his zeal in scientific realms, he never forgot his choice of occupation and many a sufferer along his routes was helped or healed by his skill. To the memory of men of Abraham Gesner's calibre the Warner policy is maintained Therapeutic Exactness . . . Pharmaceutical Excellence . . . One price and one discount to all.

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Reader's Guide

According to the most recent figures, there are 7,194 totally deaf persons in Canada, 6.3 per 10,000 population. For these, there is little or no hope of any device or technique which will permit them to hear. However, there are, in addition many, many thousands with a small degree of hearing for whom various aids can be secured. Still another small group have the form of deafness which may respond to operative treatment. It is of this fenestration operation which Dr. William J. McNally, prominent ear specialist in Montreal, has written. In keeping with our policy to bring authentic information to the nurses of Canada on relatively new techniques. we recommend this enlightening description to you for study. Bernice Stewart has been the nurse assistant in many of these operations. She emphasizes the importance of post-operative nursing care.

Gertrude M. Hall, general secretary, C.N.A., challenges us to think very seriously of the status of professional nursing in her discussion of the varieties of persons providing nursing care in most of our communities. What is to be the future of nursing in Canada? Every nurse has a responsibility to herself and to the profession at large to ponder carefully these assorted straws which tell us how the winds are blowing.

Mrs. Florence M. Wilson is clinical instructor in medical nursing at the Winnipeg General Hospital. Her thoughtful challenge to head nurses is full of suggestions on how to utilize every opportunity for student teaching.

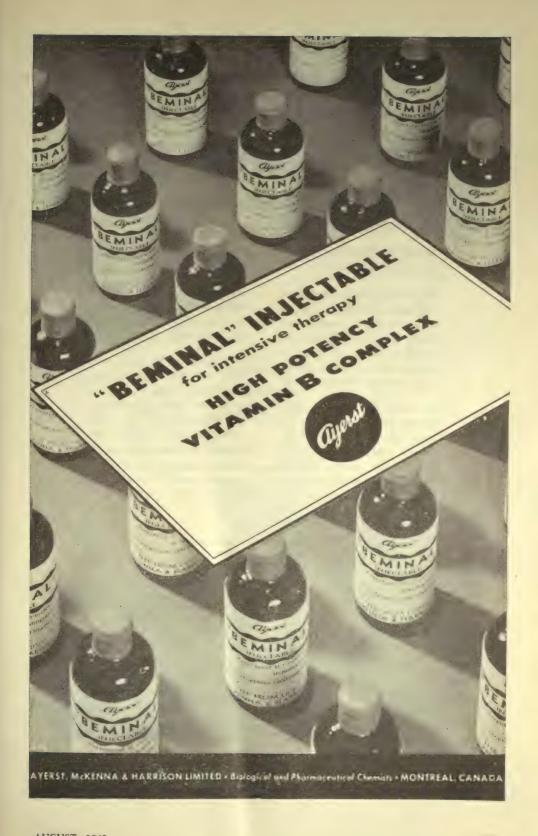
Dr. Watson Sodero, of Sydney, N. S., modestly suggested that his material on laboratory diagnosis was too elementary for nurses. We felt that for many who have been away from the classroom for a long time, it would prove a useful refresher in a nutshell. Don't you agree?

Dr. M. R. Macdonald was recently appointed director of the Cape Breton Island Health Unit in Nova Scotia. Because of his considerable experience with public health nurses, his opinion on their future is well worth studying.

Mrs. Mabel E. Brolin is secretary of the Prince George Chapter of the Registered Nurses Association of British Columbia. Such nurses as she are the backbone of the professional group providing the essential nursing services in our smaller communities.

Esther Beith, who is chairman of the National Labour Relations Committee, is the wise and beloved director of the Child Welfare Association in Montreal. She is exceedingly well informed on all matters relating to working conditions and legislation as they may affect nurses.

We are indebted to Lieut. (N/S) Bertha Jenkins, of the Military Hospital Victoria, B.C., for the interesting photographic study on our cover. Kalamalka Lake, a beautiful gem set among tawny mountains, is near Vernon, B.C.



AUGUST, 1945 585



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ANTISEPSIS

From Obstetrics to General Purposes

'A general disinfectant must possess activity against the most important pathogenic organisms and, it is suggested, against at least these three: typhoid, staphylococcus and streptococcus. Moreover, any claim made should be required to be substantiated by a test designed to prove activity in the particular conditions made in the claim. Activity in the presence of blood, serum or other organic matter is very important, for so many are ineffective in these conditions.'*

Among the original investigations of 'Dettol', not the least important was a study of its bactericidal potency against the haemolytic streptococci responsible for the great majority of puerperal infections and its capacity to form a durable barrier against these organisms. With respect to these qualities it proved far more dependable than any of the antiseptics with which it was compared; it eliminated the organisms completely in one-and-ahalf minutes; on the treated skin it provided a protective covering which could prevent re-infection for five hours; its repeated application at full strength proved harmless; on the freshly scratched skin or the vaginal

mucous membrane it caused neither pain nor other irritative effects. At Queen Charlotte's, London's great maternity hospital, the introduction of this antiseptic was followed by an over 50 per cent. decline in the incidence of haemolytic streptococcal infections.

Today 'Dettol' is preferred before all other substances not only in obstetrics, but in the operating theatre, casualty post, factory and home. For its remarkable bactericidal power is not specific to haemolytic streptococci, but extends to such common pathogenic organisms as Staph. aureus, Bact. typhosum and Bact. coli. Surgeons, physicians and obstetricians feel secure with an antiseptic which has been shown by repeated laboratory tests, confirmed by ten years' clinical experience, to be effective - even in the presence of blood, pus and wound contaminants - and at the same time non-toxic at full strength. And patients prefer it because its application, whether to wounds, abraded surfaces or mucous membranes, does not cause pain - and because it is a pleasant preparation which, unlike poisonous antiseptics, can be left in an accessible place for the use of the whole household.

& Berry, H. (1944) Pharmaceutical Journal, 3.

RECKITT & COLMAN (CANADA) LIMITED, PHARMACEUTICAL DEPARTMENT, MONTREAL

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food fads and fancies. There are more than 40 references.

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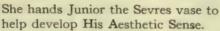
AUGUST. 1945 589

The Nurses' Album of New Mothers

NO. 6: PROGRESSIVE MRS. PARSONS



Oh, Mrs. P. has read books. She believes in letting a child express his little self...







She's proud of his lusty voice—till the doctor points out it springs not from musical leanings but from diaper rash!

Mrs. P.'s doctor prescribes a little more attention to the torso—beginning with Johnson's Baby Powder.

More doctors recommend Johnson's for baby skin care than all other brands of baby powders put together.





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CANADIAN

NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-ONE

NUMBER EIGHT

AUGUST 1945

Unlimited Horizons

A philosopher has said, "Every man takes the limits of his own field of vision for the limits of the world". The ancients, believing only what they could actually see, considered the world to be flat, with the sun, moon and stars revolving around their particular section of this flatness. When Christopher Columbus was daring and fool hardy enough to sail off the edge of the world, he changed the whole field of vision. Today when we read that the maximum elapsed time by air travel between any two spots on the earth's surface is only sixty hours, our field of vision is enlarged again. Physically there would appear to be unlimited horizons before us. Has our mental or spiritual vision kept pace with this rapid expansion? Can we see the broad professional perspective or is our vision of the future of nursing hampered by our personal shortsightedness?

The recent meetings of the Canadian Nurses Association executive, which will

be reported in greater detail in subsequent issues of the Journal, provided an opportunity to observe how broad a view the leaders in nursing in Canada have of future possibilities. Provincial representatives, thinking and planning nationally, concurred in the discussions of a wide variety of problems which are confronting us. The report of the Labour Relations Committee which appears on the Notes from National Office page in this issue is a good illustration of the scope of the activities of the national association. As a group we are prepared to support these daring explorers who have a far vision of what is best for nursing and for our patients.

But what about our capacity as individuals to look beyond our own immediate problems? Are we being myopic and so failing to see any horizons at all? Is what may happen to us personally of greater concern than how the profession as a whole shall serve the purposes for which nursing stands? The long



years of war brought unlimited opportunities for nurses, young and old, to serve. By the hundreds and the thousands they joined the armed services. Other thousands who had not thought to nurse again, often at considerable personal sacrifice have returned to fields of duty in order to fill the gaps left by their younger sisters who had gone to distant lands. The impelling demands of war have been met with a loyal agreement that has had an element of grandeur in it. What about the demands of peace?

Reduced to the simplest terms, the functions of our profession are to promote health, to prevent illness and to

provide care for those who are sick. Of these functions, the actual day-byday care of sick persons is the most exacting, the most difficult and, in the long run, the most satisfying. Since this is so, it is difficult to reconcile the repeatedly heard remark, "No more bedside nursing for me!" If we as professional nurses shirk our responsibility, the job for which we are trained, there are others who will supersede us. Let us therefore look beyond our immediate field of vision to the unlimited opportunities which await us if we do not allow selfishness, vainglory and shortsightedness to blur the horizon.

-M.E.K.

Write to Win

As announced in the May issue, the Journal is sponsoring a competition in which nurses all over Canada are invited to participate. The purpose of the competition is to encourage thinking individuals to assess the present situation in nursing and, from that vantage point, to write of their hopes and aspirations for our profession in the years to come. Every nurse who has been following the trend of developments in recent years is aware that there is nothing static in nursing today. Increased industrialization providing more money in the public's pocket-book has resulted in a hospitalization demand which has swamped existing facilities. Shortage of medical personnel has thrown new and more involved responsibilities upon the nurses. More and more nurses' aides have had to be trained to take over the simple routine duties. How are these factors going to influence the future of nursing in your community. Where are we going professionally? What do YOU think about it all?

The competition is open to any Canadian nurse, graduate or student. The articles should be not less than five hundred nor more than a thousand words in

length, written or preferably typed (triple-space) on one side of the paper only. The names of the competition judges, who are representative both of sectional interests and of the various areas of the country, will be listed in the September issue. All entries shall be submitted to the offices of *The Canadian Nurse Journal*, 522 *Medical Arts Bldg.*, *Montreal*, 25, and marked "Competition". The closing date for the entries will be *September* 30, 1945. The winning articles will be published in the *Journal*.

Prizes shall be awarded as follows: for the best article, \$25; second and third choice, \$15 and \$10 respectively. Other articles of merit will be given honourable mention. The submitted articles will be adjudged on the basis of the originality of the ideas, the clarity of thought, the pertinence of any suggestions and the ultimate value to nursing of projected plans. It is understood that all articles must be original, have not been submitted elsewhere for publication, and become the property of The Canadian Nurse.

—M.E.K.

Operative Treatment of Deafness— The Fenestration Operation

W. J. McNally, M.D.

Within recent years much has been learned about the ear in health and disease. Better methods of testing hearing in animals enabled physiologists to study the normal function of the ear. Pathological studies in large numbers of human cases added greatly to the understanding of ear diseases. The use of the vacuum tube has enabled physicists to find out more about how we hear and how to improve hearing aids.

A dramatic step forward in treatment has been along surgical lines. Many of the newer drugs have been used in the hope of bringing about improvement in hearing but so far there is no satisfactory form of medical treatment for hearing loss.

The operative treatment is applicable only in certain cases of hearing loss and the proper selection of cases is of the utmost importance.

The suitable case is one in which there is middle ear deafness with the hearing nerve in good condition. The most satisfactory results have been obtained in the young individual in good general health and with normal ear drums and a normal nose and throat. This type of deafness is called otosclerosis. The lesion consists of a bony overgrowth sealing the footplate of the stapes (one of the middle ear bones) in the oval window of the outer wall of the internal ear which houses the cochlea or ear nerve endorgan. The stapes becomes immobile and fails to transmit the sound waves from the drum to the nerve. The operation is designed to make a new opening or window in the wall of the internal ear to replace the one which has been closed by the bony overgrowth. If the ear nerve is not in good condition it cannot conduct the sound to the brain

and the operation does not improve the hearing.

The proper selection of cases is not an easy matter because the methods of testing hearing and the equipment for testing hearing, particularly the equipment for testing bone conduction, are not standardized. Testing the patient's ability to hear pure tones by air conduction can be done with a fair degree of accuracy by using an audiometer. The chief difficulties are in testing the patient's hearing for bone conduction and for speech. The bone conduction tests are particularly important in judging the amount of nerve deafness present. It has been determined that the audio-

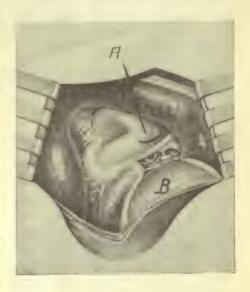


Fig. 1. Drawing showing the fenestra or window A over the ampulla of the right horizontal semicircular canal (stopple in position). B is the skin flap of the external canal attached to the drum. (From Julius Lempert, Arch. Otolaryngol. Vol. 41, Jan. 1945).

meter readings for bone conducted sounds within the speech area — from 512 cycles to 2048 cycles — should be within thirty decibels of normal. The bone conduction should also be tested with tuning forks to confirm the audiometer tests.

The fenestration operation has been in the process of evolution since about 1876. Jack (1895) removed the stapes in sixty patients. Jenkins in 1915 described an operation in which he made an opening in the internal ear through the horizontal semicircular canal. A great difficulty has been to keep the opening in the bony wall from closing. Holmgren (1917) and Sourdille (1929) reported improvements in Jen-

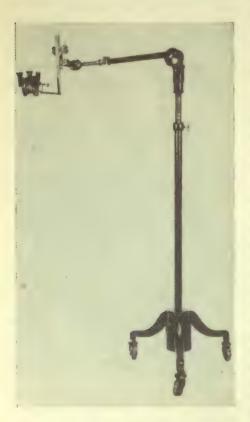


Fig. 2. An operating microscope adapted from a Zeiss Colposcope and an improvised floor mounting. (Mechanical work by Wm. J. Jones, Royal Victoria Hospital, instrument repair dept.)

kins' operation but their operations were in several stages. Lempert (1938) described a technique in which Sourdille's operation was done in one stage and the incision was through the external canal — the endaural approach — instead of behind the ear over the mastoid. Lempert also found that if the opening in the horizontal semicircular canal was made at the ampullated end the window could be made larger and was more likely to remain permanently open. Shambaugh (1942) further simplified the technique by advocating the use of a dissecting miscroscope which provides about seven times magnification and enables the operator to more easily avoid damage to the membranous internal ear when making the new window, He also advocated a continuous flow of irrigating fluid while drilling the window in the bone thus reducing the likelihood of bone dust and blood entering the internal ear.

The operation might be described as a microscopic plastic to shift the ear drum and its attached skin in order to cover the new window leading into the internal ear through the horizontal semicircular canal.

At the beginning of the operation the incision is made in such a way as to enlarge the opening of the external ear canal. Through this opening the mastoid cells are removed and the incus and the malleus, two of the bones in the top of the middle ear, are exposed. The bony wall of the external canal is carefully removed so as to leave the skin of the external canal intact and attached to the drum. The incus is removed and the head of the malleus is excised and'removed. The window or opening is then drilled through the ampullated end of the horizontal semicircular canal, care being taken not to injure the underlying membranous canal which is part of the body's balancing mechanism (Fig. 1). This part of the operation is done under microscopic vision (Figs. 2 and 3). A flap of the skin of the external canal is

then cut and the upper part of the ear drum is separated from its attachments so that the skin flap attached to the ear drum is swung inward and placed in position over the new window in the internal ear (Fig. 4).

It is thought that this drum-skin flap in some way carries the sound waves to the new window. It is also thought that the flap tends to prevent the formation of new bone closing the window.

An important consideration at operation is the need to avoid infection, through blood and bone dust entering the internal ear because of the possibility of labyrinthitis and meningitis. If any of these complications occur there may be not only a loss of hearing but even a loss of life.

When the operation was first developed in many cases the bony window closed. This still may occur but it is less likely with the newer techniques. Usually the closure takes place within the first six months but it may occur within the first or even the second year after operation.

The improvement in hearing takes place slowly within the first few months after operation and the hearing may continue to improve within the first post-operative year.

If one considers all the cases that have been operated upon it is probably fair to say that about 50 per cent have had a return of hearing to a practical level. The hearing rarely, if ever, returns to normal. A good result is a gain of twenty-five to thirty-five decibels in hearing within the speech range when the average hearing loss was not more than about sixty-five decibels before operation.

In view of the fact that this operation is still in the experimental stages every patient should be told everything possible about it so that he is in a position to decide as to whether or not he will submit to it. The dangers and complications should be stressed more than the advantages.

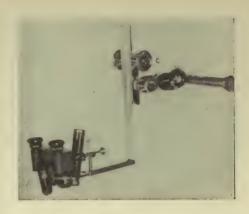


Fig. 3. A close-up view of the microscope showing how we arranged the anterior A and posterior B lights. Also the hand screw adjuster C can be seen. It was adapted from an old microscope. It is placed at ten inches from the eye-pieces to avoid contamination of the hand by the head. The great advantage of the Colposcope is that the focal distance at seven times magnification is 15 cm. This allows sufficient room for manipulating instruments between the wound and the scope.

It should be pointed out to these patients that they are well suited to wearing a properly selected electrical hear-

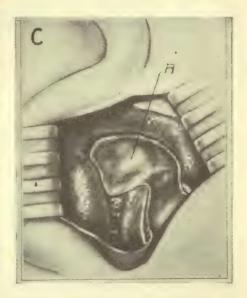


Fig. 4. Drawing showing skin-drum flap A in position over the new window in the internal ear. (From Julius Lempert).

ing aid. With such a hearing aid they could expect to get just as much or more improvement in hearing than they could hope to get from a successful operation. They should also be told that with information gained during the war about vacuum tubes and batteries the post-war hearing aids should be very much superior to any of the instruments now on the market. If the patient has been made aware of all the above facts and he still would prefer to have an operation, then the well-trained operator may feel free to carry out the operation providing he has satisfied himself that the patient is a suitable case. He should not be too much influenced by a patient's willingness to have an operation no matter how poor the chances for success may be.

If progress is to be made in this important problem the patients must be followed for many years post-operatively. The hearing should be tested repeatedly and the results faithfully reported in the medical journals so that operating surgeons may compare their results and all benefit from the contributions of each.

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Nursing Care Following the Fenestration Operation

BERNICE STEWART

The nursing care of a patient subjected to the fenestration operation for deafness is of particular importance. If infection occurs at operation, it not only lessens the possibility of improvement in hearing, but it is a real threat to the patient's life because of the imminence of meningitis. The operation, in most cases, is a long and difficult procedure and the patient requires careful nursing during the post-operative period. The postoperative care of the wound is almost as important as the actual operation itself. Every effort must be made to avoid the introduction of secondary infection before the wound has completely healed.

The sterilization of the instruments must be done with the same scrupulous

detail as would be necessary in the case of a neuro-surgical procedure. All sharp and delicate instruments are soaked in 94 per cent alcohol for twenty-four hours before operation. Drill points, sharp elevators and mastoid curettes are boiled for six minutes in 2 per cent sodium hydroxide. The ordinary instruments, including artery forceps, mastoid rongeurs, etc., are boiled for twenty minutes in soda water. The whole drill head of the electric dental drill is detached and autoclaved, being well oiled with sterile lubricant before and after autoclaving. Two important parts of the technique are the suitable draping of the dissecting microscope (Fig. 5) and of the drill. Before these can be properly done without danger of contamination a considerable amount of practice by the operating room nurse is required.

In such a delicate operation as this it is most essential that the nurse and surgeon work as a well-trained team. All details must have been previously decided upon by the surgeon and his operating room nurse.

The post-operative dressings should be carried out under strict sterile precautions. Unless there is a special dressing room it is advisable to do the first dressings in the operating room. The detailed set-up necessary should be decided upon by the surgeon and the operating room nurse. As a rule, dressings are done every second or third day and the patient remains in hospital about two weeks after operation. Subsequent dressings are done at the doctor's office, still using sterile precautions.

The post-operative nursing of the patient, as mentioned before, is important because many operators have chosen to use intravenous anesthesia or very heavy pre-operative sedation and as a result the patient may remain asleep for many hours after operation. This requires special vigilance on the part of the nurse to check the patient's breathing, to watch the circulation, to prevent pressure sores, etc. During the first few days post-operative it is frequently nec-



Fig. 5. The microscope fully draped. A special adapter has been devised to keep the drapes from covering the lenses and lights. The eve-pieces are covered by sterilizable rings similar to those used by Shambaugh.

essary to resort to intravenous feeding, when careful note must be kept of the patient's intake and output.

In view of the fact that the new bony window is made into the balancing portion of the internal ear almost all patients are troubled with severe vertigo on awakening. This is frequently associated with nausea and vomiting and may persist for about two to four weeks. The patient must not be allowed out of bed unless supported by some one and must be warned not to attempt any movement of locomotion alone until the unsteadiness has subsided.

Laboratory Diagnosis

G. WATSON SODERO, M.D.

Laboratory diagnosis is growing in importance in present day medicine. By laboratory diagnosis we mean the chemical and microscopic examination of the fluids of the body in health and disease — the examination of the urine, stools, blood, spinal fluid and stomach contents and in diseased states the examination of sputum and pleural and peritoneal effusions.

Examination of the urine is routinely done on every patient entering hospital today. In this way, many cases of unsuspected diabetes are discovered cases which if given an anesthetic without proper treatment would very likely end disastrously. Cases of latent and unsuspected nephritis are often discovered as are also cases with inflammatory infections of the kidneys and urinary

tract. You may ask why these cases should be unsuspected by the physician. The answer is that the condition may be present without any marked symptoms or with atypical symptoms. Nowadays examination of the urine is done regularly throughout pregnancy. It is not so many decades ago that many women went through their entire pregnancy without having a urinalysis done. This explains why convulsions in pregnancy, not uncommon a few years ago, are comparatively rare today. Some authorities say that practically every case of eclampsia can be discovered early by regular examination of the urine and the development of convulsions prevented by treatment. Estimation of the amount of urea in the urine, following a dose of urea by mouth, constitutes an important test of kidney function.

Examination of the stools discloses parasites, pus and blood, and an excess of fat in pancreatic deficiency. The common parasites are pin worms, round worms and tape worms. Pus is present in ulcerative colitis. Gross blood can be detected by a layman but the presence of occult blood in the stools can only be detected in the laboratory. This is of great value when slight, continued bleeding occurs from ulceration or carcinoma of the stomach or intestines. Some cases, by this means, are diagnosed before there are any clinical signs or x-ray findings. In every case of severe secondary anemia, where the cause is not evident, the stools should be examined for occult blood.

Examination of the blood is used in the detection of a variety of conditions. Blood counts are most often done to determine whether a patient is anemic and the degree of anemia present. The number of red cells (per cu. mm.) is counted and the percentage of hemoglobin estimated. Examination of the patient's eyes or mucous membranes does not tell with any degree of accuracy whether or not a patient is anemic, and it is much wiser to have a blood count done.

The white cells of the blood should be counted too. They will be raised in inflammatory conditions, such as pneumonia or appendicitis. They are lowered in tuberculosis and in agranulocytosis a condition in which the ability of the blood-forming organs to produce this type of blood cell is depressed. Sulfa drug therapy sometimes causes this condition and white cell counts should be done frequently when the patient is undergoing sulfa treatment. The number of white cells is greatly increased in ieukemia — a malignant disease of the blood. In the earlier stages there may be no other obvious physical signs.

Blood smears should also be made and stained, and a differential count done; by this means the number of each type of white cell is counted and expressed as a percentage. The diagnosis of pernicious anemia is made mainly on the examination of blood smears and often the expert opinion of a pathologist is necessary. By the examination of these smears, the actual size of the cells can be determined by measuring their diameters. In pernicious anemia the cells are larger than normal and this is called a megalocytic anemia. In most secondary anemias the cells are below the average in size and they are called microcytic. Thus a routine blood count may disclose an unsuspected case of pernicious anemia or leukemia.

The Wassermann test for syphilis is a complement fixation test using the blood serum. It is now done routinely on all patients in some hospitals, and many more cases of syphilis are discovered which would otherwise go untreated. More and more practitioners are doing routine Wassermann tests on pregnant women, because congenital syphilis in the new-born infant can be prevented if the disease in the mother is discovered before the fifth month and she is given proper anti-syphilitic treatment throughout her pregnancy.

Examination of the blood urea or non-protein nitrogen is a test of kidney

function. In more serious cases of renal insufficiency, there may be retention of nitrogenous products, especially urea in the blood, so that the blood urea, instead of being the normal 20-40 mgm. may be considerably raised. This is particularly true in some types of chronic renal disease, sometimes in acute nephritis and in kidney changes, secondary to the obstruction caused by an enlarged prostate. Nowadays, surgeons routinely do this test on their older patients before an operation. They recognize the fact that in days gone by, when the examination was not done, some of their post-operative deaths were due to kidney failure which might have been prevented by proper investigation and treatment. In the pre-operative care of prostate cases this test is used to indicate the most favourable time for operation. It is also used to determine whether the operation should be done in one or two stages.

The sedimentation rate is now done fairly frequently. If blood is citrated and thus kept fluid and placed in a vertical tube, the corpuscles settle from the plasma at a fairly constant rate. A great increase in the rapidity of the sedimentation rate is observed in many infections, pregnancy, carcinoma, and other conditions. The test has little diagnostic value but it has its place in prognosis. For instance, the rapid sedimentation rate of pulmonary tuberculosis may become slower as the patient responds to treatment. Similarly the test may have a prognostic value in nephritis and in rheumatic fever - a lowering of the rate indicating improvement. A rapid sedimentation rate is considered as evidence of activity in rheumatoid arthritis, and is taken as one indication for gold therapy.

The clotting time is the time taken for blood to clot, normally 1-2 minutes. It is greatly prolonged in hemophilia. The bleeding time is the length of time the blood continues to flow when the finger is pricked. Normally it is about

four minutes. In certain forms of purpura it may be prolonged. Both these tests are routinely done before the operation of tonsillectomy. If above normal the patient is given calcium and vitamin K, until the tests are normal, before operation is performed. Whether because of this precaution or because the operation is performed more skilfully, cases of hemorrhage following tonsil operations are much less frequent than they used to be.

The prothrombin time, estimating the level of the prothrombin in the blood, is a relatively new test. It has to be done daily to control the administration of heparin and dicumarol, two new drugs used to diminish the clotting time of the blood, in such diseases as acute thrombophlebitis.

Examination of the cerebro-spinal fluid is so important that no neurological diagnosis can be considered complete without it. Elaborate chemicals and microscopic methods are now available which are of great help in many cases, and frequently essential. Blood is found in the cerebro-spinal fluid in basal fractures of the skull, leakage of cerebral anurysma, ventricular hemorrhage. The fluid may be turbid or definitely purulent in meningitis, especially meningococcal meningitis. A microscopic cell count aids in the diagnosis of tuberculous meningitis and of syphilitic meningitis. Also the fluid may be examined for bacteria and the causative organism identified. A Wassermann test done on the fluid is usually positive in syphilis of the nervous system. When positive in the spinal fluid it is usually positive in the blood, though exceptions occur. The reverse is not necessarily true and neuro-syphilis cannot be established on a positive blood Wassermann alone, even though the signs of a nervous lesion are present.

Examination of the stomach contents is an important laboratory procedure and an aid to the diagnosis of pernicious anemia, subacute combined degenera-

tion of the cord, gastric and duodenal ulcer and cancer of the stomach.

It is not necessary that every patient be subjected to all these laboratory tests. The history and clinical examination of the patient, will, in ordinary cases, give the clue as to which laboratory investigations are applicable to that particular case. In any case in which the diagnosis is at all obscure, a complete laboratory investigation should be done. In the past there has been a tendency on the part of the practitioner to limit his investigation because of the fear of putting the patient to unnecessary expense; but in a case where the diagnosis is not evident, the patient's health, and not his pocket book, should be given primary consideration, and no doctor should be called upon to make a diagnosis until he has all the facts at his disposal.

Standing Orders for Nurses in Industry

Editor's Note: The Committee on Industrial Medicine of the Canadian Medical Association has adopted for use the "Standing Orders for Nurses in Industry", developed by the Council on Industrial Health of the American Medical Association. With the kind permission of this Council, we are reproducing most of the details included in these standing orders which are printed in full in the Journal of the American Medical Association, August 28, 1943, Vol. 122, pp. 1247-1249.

GENERAL RELATIONSHIPS

Standing orders represent a preliminary understanding between physician and assisting personnel about routine conduct of a medical service. In establishing such orders in an industrial medical department, several considerations need to be borne in mind:

- 1. The greater the amount of personal supervision exercised by the physician directly in the industrial environment, the better is the industrial health service.
- 2. Standing orders cannot be written to meet every situation likely to arise in industry. They must be modified to meet specific requirements and in accordance with the training and professional competence of the assisting personnel. They should be signed by the supervising medical authority and posted prominently in the medical department.

3. The nurse in industry should assume no responsibility for service outside the field of her professional training. This applies particularly to individual case management, from which the nurse should rigidly abstain except: (a) In emergencies demanding immediate independent judgment and action; (b) procedures of preliminary or first aid nature routinely required by reason of the nature of the work and which are clearly stipulated in the standing orders.

This statement confines itself mainly to these last named aspects of mediconursing relations in industry.

EMERGENCY PROCEDURE IN INDUSTRY

General principles which operate in all emergency situations apply to industry as well. They are: (1) Call a physician immediately; (2) stop bleeding; (3) restore breathing; (4) prevent shock and infection; (5) do no more than is actually needed.

The supervising physician should assure himself that these instructions are thoroughly understood and should institute special training when necessary. Nurses in industry should qualify as first aid instructors.

Emergency Supplies: Emergency packs with essential sterile supplies should be available at all times in the medical department and in first aid kits suitably

located throughout the plant. Regular inspection is necessary.

Hemorrhage: Bleeding calls for immediate attention. The nurse should notify the physician and, until he arrives, proceed as follows: (1) Expose the wound; (2) remove obvious foreign matter; (3) apply pressure.

Direct manual or bandage pressure firmly applied over sterile gauze packing at the bleeding site will effectively control moderate hemorrhage. Indirect compression is indicated in excessive bleeding not controllable by direct methods. Digital compression over the vessel against underlying structures either adjacent to the wound or at the nearest pressure point will usually suffice until the physician arrives. Indirect pressure should be applied proximal or distal to the wound, in keeping with the arterial or venous character of the bleeding. Hemostats or clamps should be applied whenever the emergency warrants it.

Avoid applying a tourniquet if possible. If severe bleeding in an extremity suggests the use of a tourniquet, apply a blood pressure cuff. The nurse should remember that: A direct pressure bandage should not act as a tourniquet; a tourniquet must be periodically released at least every fifteen minutes; no dressing should be applied over a tourniquet; asepsis must be observed at all times.

Asphyxia: Cessation of breathing from any cause demands: (1) Artificial respiration at once and at the site of the accident; (2) notification of the physician; (3) maintenance of body warmth. Avoid excessive heating.

All industrial nurses should demonstrate ability to apply artificial respiration by the prone pressure method and should realize the need for its continuous application until breathing is restored or until careful repeated medical examination advises otherwise.

Shock: Early and adequate shock treatment is life saving. Do not delay. Common symptoms of shock following

injury are pallor, perspiration and rapid thready pulse. Emergency management by the nurse should include: (1) Notification of the physician; (2) removal of cause - if shock is due to hemorrhage, control it. If it is due to trauma not associated with bleeding, all active treatment of injury should be deferred until shock management has been instituted. Wounds should be covered with sterile dressings to prevent infection. (3) Relief of pain: 1/6 to 1/4 grain (0.010 to 0.016 Gm.) of morphine sulfate, repeated if necessary, or barbiturates as routinely ordered except in injuries to the head or trunk. (4) Keeping the patient warm, dry, and on his back with his head low. Avoid overheating,

ROUTINE NURSING CARE OF INJURIES

Successful medical management of industrial injuries depends on: (1) Prompt treatment; (2) meticulous cleansing and dressing; (3) examination of deep as well as superficial structures.

To accomplish these aims the routine functions of the nurse should be confined to care of minor wounds as follows: (1) Protect wound with sterile gauze while adjacent area is cleansed with soap and water or solvent; (2) discard protective dressing and clean wound margins; (3) irrigate wound with sterile water or isotonic solution of sodium chloride; (4) apply antiseptic of physician's choice; (5) apply dry sterile dressing, interfering as little as possible with function. Sterile dressings should be covered with protective material for use at work. The worker should be instructed not to remove the dressing but to return to the medical department if it becomes loosened or uncomfortable.

The nurse should do no more than is actually needed. The following conditions require direct medical supervision: (1) Wounds requiring debridement; (2) those with obvious or suspected involvement of deep structures; (3) wounds with edges which do not

approximate; (4) wounds about the head and face; (5) contaminated wounds requiring tetanus prophylaxis.

Management of Common Injuries: Injuries most likely to be encountered in industry include the following conditions:

- 1. Abrasions: Clean and apply dry dressing. Extensive or deep loss of skin, especially about the fingers and hands, needs medical attention.
- 2. Contusions: Treat with cold compresses directly following injury, later with moist heat. If soreness or disability persists or if deep involvment is suspected, refer to the physician.
- 3. Lacerations: Clean and apply dressing as directed. Any possibility of injury to joints, nerves or tendons should be brought to the physician's attention at once.
- 4. Puncture Wounds: Puncture wounds through the skin need direct medical supervision to avoid or treat severe infection. If superficial, clean and apply sterile dressing.
- 5. Slivers and Splinters: Penetration through the skin by slivers or splinters always carries the risk of an infected puncture wound and should be treated as such. Those lodged superficially and easily removed without added trauma or incision may be extracted aseptically by the nurse.
- 6. Burns and Scalds: Clean minor burns with soap and water. Apply petrolatum or 5 per cent boric acid ointment, bandaging firmly without interfering with function. Leave blisters alone.

In all other cases: (a) Notify the physician; (b) cover the burned area with a sterile dressing or sheet moistened with isotonic solution of sodium chloride or 5 per cent sodium bicarbonate solution; (c) combat pain and shock.

In the absence of specific orders, chemical burns should be treated by irrigation or immersion in water for at least twenty minutes and then by dressing. 7. Sprains and Strains: Treat first with cold compresses, elevation of the part and rest. A physician's advice is necessary regarding strapping, other methods of support or fixation, further examination or special therapy.

EYE INJURIES

Rigid aseptic technique must be scrupulously observed in all eye conditions. Never attend consecutive patients without sterilization of instruments and careful hand washing. Remember that early symptoms of infection simulate foreign body.

Minor Burns: Do not apply ointments to minor burns of the skin about the eye. Apply a sterile dressing and refer to the physician.

Burns of the Eye: 1. Chemical Burns: Irrigate chemical burns of the eye copiously and at once with water, preferably by immersion. Neutralizing solutions are usually inadequate or unavailable. The rapidity with which the irrigation occurs is more important than the type of solution used. Continue to irrigate at least twenty minutes by the clock.

2. Hot Metal Burns: Apply a sterile pad and refer at once to a physician. Do not irrigate. An anesthetic should be applied as ordered by the doctor. Every burn of the eye should receive competent medical attention early.

Foreign Bodies: The nurse should attempt to remove only those foreign bodies of the eye which can be readily located and which can be easily washed out or removed with a dry sterile cotton applicator. An antiseptic may be applied if the physician so orders.

Direct medical care is essential: (1) If the foreign body cannot readily be located — stains to aid in the location of foreign bodies should be used only on specific medical order; (2) if removal requires any instrumentation; (3) if irritation or pain persists after removal.

No person with an eye injury should be discharged without examination by a

physician.

"Flash" Injury: First aid treatment should include local anestheic as ordered; cold compresses; sedatives. Persistent pain following flash needs medical examination and treatment.

Conjunctivitis: Conjunctivitis or other forms of conjunctival irritation should be referred routinely to the physician or ophthalmologist.

FRACTURES

Preliminary steps for the nurse are: (1) Call a physician at once; (2) keep the patient quiet and warm; (3) immobilize before any movement is attempted; (4) do not attempt reduction; (5) if the fracture is compounded, cover the site of the fracture with a dry sterile dressing. Do not cleanse or reduce. Special instruction in splinting should be provided every industrial nurse.

HEAD INJURIES

Until the physician takes over, the nurse should keep the patient lying down; elevate the head; apply ice cap or cold compress (no sedatives); record pulse and respiration every ten minutes; clip or shave and cleanse areas adjacent to scalp lacerations, and cover with a sterile pad.

CHEST AND ABDOMINAL INJURIES

Contusions of the chest and abdomen with or without external evidence of injury may result in trauma to underlying organs. Until seen by the physician, such patients must be kept warm and quiet; allowed no sedatives; have pulse, temperature and respiration recorded frequently; suitably bandaged to avoid contamination; in case of abdominal injury give nothing by mouth.

Non-occupational Illness

Treatment of injury or illness which has no relation to occupation is not a function of the industrial medical department except:

- 1. First aid for emergency sickness. Such measures as the situation demands must be taken until notification of the family physician discharges responsibility.
- 2. For minor ailments which temporarily interfere with an employee's comfort or ability to complete a shift and for the relief of which a physician would not ordinarily be consulted.

In all relationships of this kind, judgment and tact are required of the industrial nurse. Several principles apply:

(1) Before giving any treatment, the temperature, pulse, general appearance and a history of the presenting complaint should be recorded; (2) palliative treatment, especially for chronic or recurring disorders, should not be repeated.

Every properly trained nurse understands the difference between attention of this kind and systematic treatment.

CARE OF MINOR ILLNESS AND SYMPTOMS

Persistent or augmenting symptoms of irritation, discomfort or disability suggest faulty work environment. The nurse should not hesitate to ask for medical examination of workers and of the premises.

Fever: A rise in temperature of 1 degree suggests medical consultation before work is resumed. Findings should be checked by repeated thermometer recordings.

Headache: Record temperature. If headache is accompanied by dizziness, nausea, vomiting, stiff neck, injury, history of recurrence, fever, general malaise or other symptoms the patient needs medical attention. If not, give an analgesic as ordered by the physician. Remember that headache or dizziness may be premonitory signs of intoxication.

Unconsciousness: 1. Fainting: Usual symptoms are pallor, with shallow breathing, slow and weak pulse. Period of unconsciousness is of short duration. Keep the patient lying down with head lowered until fully recovered. Be sure the patient has plenty of fresh air. Clothing should be loosened and stimulating inhalants used, such as ammonia or smelling salts.

2. Other causes: If other signs are present or if unconsciousness persists longer than a few minutes, call for medical assistance. Give nothing by mouth.

Toothache: If there is a cavity, the nurse may pack it with cotton dipped in oil of cloves for temporary relief. For further examination and treatment refer to a dentist.

Nosebleed: Spontaneous nosebleed may be treated by cold packs or pinching the sides of the nose against the septum. Keep the patient sitting erect or standing and loosen the collar if it tends to constrict the neck. Advise the patient not to breathe or blow through the nose for an hour or two after bleeding has stopped. Bear in mind that certain occupational exposures are manifested by nasal damage and bleeding.

Sore Throat: Patients with sore throat may be given a hot saline gargle if they have a normal temperature. Do not "paint" the throat. Any persistent sore throat or one associated with fever needs medical care at home.

Respiratory Irritation or Infection: Repeated or persistent signs of bronchial or chest irritation without associated infection suggests an unfavourable occupational exposure. A plant hygiene survey is indicated. Persons having acute respiratory infections with elevated temperature, cough, sneezing or nasal discharge should be sent home for proper segregation, rest and medical attention. In mild infections, work may be continned, if under medical or nursing supervision simple measures will control symptoms and prevent spread.

Available medical evidence at the present time cannot support routine administration of cold vaccines or vitamin preparations as methods of reducing the incidence or severity of acute respiratory infections. Frequent colds or chronic respiratory conditions require special medical consideration.

Abdominal Distress: Early signs of occupational intoxication may be abdominal in character. In any case abdominal distress, nausea or pain, especially if severe or persistent, requires competent medical diagnosis and management.

Laxatives should never be dispensed from an industrial medical department,

Dysmenorrhea: Painful menstruation not associated with fever or gastro-intestinal disturbances may be treated with an analgesic ordered by the physician and the patient placed at rest with heat to the lower part of the abdomen. If there is no relief or if other signs or symptoms present themselves, she should be referred to her physician.

Patients with recurrent severe dysmenorrnea should not be given palliative treatment. They should be referred for examination and treatment.

DERMATITIS

Management of skin disorders in industry depends on cause.

Specific Irritents: Materials or processes in the plant capable of causing skin disease should be identified an 1 special orders provided for control. Competent dermatologic consultation is essential in all obscure or refractory situations.

Non-specific Skin Disease: Non-specific skin irritation in industry is almost entirely assignable to faulty personal hygiene. The nurse can do much to improve washing routine, the use of de-

pendable protective coverings, the wearing of clean work clothing, maintenance of satisfactory housekeeping in the plant and the general maintenance of accepted hygienic procedure.

PREGNANCY

A definite policy regarding employment during pregnancy should embrace the following recommendations:

- 1. The employee should notify the proper authority in industry about her pregnancy within the first trimester.
- 2. She should obtain a statement from her own physician (a) that her work is not contra-indicated; (b) regarding the length of time she should work.
- 3. Special attention should be given to the nature of the work. Pulling, pushing and lifting must be kept within safe

limits. Rest periods will tend to minimize emotional and physical instability during pregnancy.

- 4. Ordinarily work should terminate by the thirty-second week (within six weeks of term). If contra-indications arise within this period, the employment should stop.
- 5. Return to work is inadvisable before six weeks after delivery and then only on notification of the employer by the physician.

EQUIPMENT AND SUPPLIES

Space which can command privacy and which can be kept clean and properly prepared for emergency and routine services by the nurse should be provided in the plant. Special attention should be given to heating, light, ventilation and accessibility.

Nursing Care for All the People

GERTRUDE M. HALL

The whole field of professional and vocational nursing is one of such complexity that one cannot begin to present all aspects in one easy lesson. I shall take it for granted that all are familiar with the many excellent articles relating to this subject which have appeared in our nursing and hospital journals. Some of the very best have been prepared by eminent members of the medical profession. I refer particularly to "The Future of Nursing", which was given by Dr. H. B. Atlee at the biennial convention in 1938 and was later published in The Canadian Nurse in September, 1938. Dr. Joseph Mountain, medical director, United States Public Health Service, published an article in the April, 1944, American Journal of Nursing, "Sug-

gestions to Nurses on Postwar Adjustments". Everyone, we trust, has studied "The Preparation for Professional Nursing" by Nettie Fidler, in which Miss Fidler has presented very clearly the problem in relation to the Canadian situation. These are but a few of the interesting and informative sources of material for study.

Do we as a group really know what we mean when we talk about subsidiary workers? At one of the provincial annual meetings which I had the privilege of attending recently, a panel of nurses and a lay woman discussed the subsidiary nursing group. Following the presentation by the speakers, the discussion from the floor revealed much confused thinking. Many nurses were

totally uninformed on these important issues. If we as a professional group do not know what is happening within our profession and what is likely to happen, unless we are prepared to give leadership and direction, how can we be critical of the lack of an informed public? Can we censure lay people when they employ women to care for the sick who lack what we consider to be the essential qualifications and preparation? What is our responsibility? How can we as individuals inform the public intelligently. These are questions that every nurse must ask herself at this time. I quote from an article which appeared in Hospitals, October, 1944, "Some Trends of Today that will help Shape Tomorrow's Hospital", by F. G. Carter, M.D., superintendent, St. Luke's Hospital, Cleveland:

War necessities have demonstrated previous statements that 50 per cent of nursing duties were of a non-professional nature, to be very conservative. We have seen women, trained in as little as eighty hours, do in creditable fashion numerous tasks which previously many nurses had claimed should be done only by professional nurses.

Hospitals cannot afford to pay professional salaries for non-professional work. Some kind of adequate bedside nursing is the backbone of good hospital service, yet our nurses are being educated to the point where they have an investment that does not permit them to do the simpler types of nursing. When hospitals pay professional salaries for such tasks they are paying for talents that are not needed and are not used.

Some one, preferably the nurses themselves, must sift out of nursing all the activities which can be carried on by people of non-professional status. What we need in the hospital and health fields today is a less highly trained group for routine duties and a more highly trained group for medical technical service of all kinds. A vast field awaits cultivation in the latter area and the nurses are the logical ones to do the cultivating.

Here is a challenge to nurses to so inform themselves that they may participate in formulating plans for the preparation of more than one type of nurse.

In the May, 1945, American Journal of Nursing, there appeared an article by Edward L. Bernays, public relations specialist, entitled "The Nursing Profession — a Public Relations Viewpoint". He states:

Good public relations between the nursing profession and the public depends on two factors. One is that you and the public understand each other; and the other is that you definitely meet the real needs of the public for nursing service.

One of our objectives, as stated in the Constitution and By-laws of the Canadian Nurses Association, is: "To elevate the standard of nursing education and practice, in order to render the best type of public service". Similarly, each of the Provincial Registered Nurses Association Acts has as one of its major objectives a statement such as: "To maintain the honour and status of the nursing profession and render service in the interest of the public".

This immediately raises questions which we must seriously consider. Are we sincere in these statements? Are we really concerned with the necessity for the provision of a complete nursing service, both preventive and curative, for the nation, taking into account questions of demand and supply and putting available skill to the most profitable use in the interests of the public? If we can answer those questions honestly and frankly, then we are ready to take the next step in our approach to a study of the ways and means by which adequate nursing service can be provided for all the people.

More than two years ago, in January, 1943, to be exact, our own Canadian Nurse Journal published Section 1 of the report of the Nursing Reconstruction Committee for Great Britain. It will be recalled that this report was prepared by a committee sponsored

by the Royal College of Nursing, of which Lord Horder, M.D. is the chairman and Miss F. Goodall and Mrs. H. M. Blair-Fish are joint secretaries. The report differs from all previous surveys of nursing service and nursing education, because it assumes that the position of the assistant nurse is pivotal and that "her status offers the key to the improved training and employment of her senior partner, the State Registered Nurse".

The first section of the report concerns the instructions, qualifications, control and employment of the assistant nurse. It may be asked why the section of the report dealing with this grade of nurse should take precedence over those sections which concern the State Registered Nurse, but a review of the position from a national rather than a sectional angle shows that the position of the assistant nurse is pivotal. Far from lacking importance, the assistant nurse of the future, as envisaged by the committee, should become one of the most stable elements in the national nursing service, an integral part of the profession and, again we repeat, a person whose status offers the key to the improved training and employment of her senior partner, the State Registered Nurse. Moreover, it is only when the services of the assistant nurse have been defined and regulated that matters affecting the State Registered Nurse can be brought into line. When carefully studied and analyzed, the British approach to the complex problem of solving total community needs seems most logical.

Turning now to the Canadian scene, there is not at the present time, nor has there ever existed in Canada, a Nurse Practice Act. Any woman, with or without training, may wear a nurse's uniform and present herself as one skilled to give nursing care. If, however, she calls herself a registered nurse and is not entitled to do so, she does so in violation of the various Acts respecting registration. Other than this, she may call herself a

"nurse", render care to the sick and accept remuneration for so doing. There are no data at hand which would reveal the extent to which women without training, or with little training, render nursing service for remuneration. It is definitely known that there is an undetermined number of women without any training whatever who accept calls for nursing care and are remunerated for their services. Legislation to provide for licensing and enrolment would bring this group into the open. Then some preparation for service could be given and supervision of their activities would be possible.

It is not an exaggeration to say that the people of Canada never have been provided with adequate nursing service. Within the whole structure of nursing service there are inherent defects which operate less conspicuously in normal times, but in periods of stress, such as economic depression or world war, the results of these defects are cumulative and are frequently misinterpreted as causes. It would be impossible to overstate the complexities of the whole problem of nursing in Canada and elsewhere. In Great Britain and in the United States, research committees have been working toward amelioration of nursing problems, and it will be necessary for us to keep in touch with findings and recommendations of these committees, since nursing is international in its philosophy and organization and many reciprocal international agreements have been in effect for a number of years. These agreements do not, as yet, include any but nurses who are registered according to their own provincial and national legislative acts, but the time may not be far distant when this reciprocity may be extended to include the licensed practical nurse.

It is conceded by those who are competent to judge in Great Britain, Canada and the United States, that there is a place for the services of the "assistant" or "practical" nurse, but that ser-

vice must be directed, supervised and controlled by legislation. While I do not propose to deal with all the problems of professional nursing, it must be acknowledged that those problems and the problems of the subsidiary worker as so interrelated as to be inseparable, and these combined problems have a grave and direct bearing up adequacy or inadequacy of nursing service. There are certain factors which should be kept in clear focus by any agency vested with responsibility for the administration of legislation respecting the subsidiary worker in the nursing field. Very briefly, then, some of these factors are:

- 1. Nursing care has up to the present depended upon the patient's financial status and not upon his actual needs.
- 2. There is not at present, nor has there ever existed, any satisfactory plan whereby nursing care might be graduated according to the degree or type of illness. Frequently when a patient could afford his own "special nurse" there has been a tendency to retain her services long after he required the services of a professional nurse.
- 3. There has been faulty distribution of skilled nursing care because nurses, like other professional workers, have shown a disposition to remain in or gravitate toward the larger centres where living and working conditions have been more satisfactory.

These are factors which must be kept in clear focus before proceeding to legislate for the non-professional or subsidiary group. They, too, require the sense of security that stems from the assurance that they are, or will be, adequately prepared for the work they will be called upon to do, and from the knowledge that they will enjoy a certain amount of economic security and feeling of personal worth. Such legislation must protect them from exploitation of any sort.

Our concept of the words "nursing care" is undergoing a rapid change. This is due in part to trends and developments occurring during the war. Many duties once considered the sacred

prerogative of the graduate nurse are now being done, and well done, by partially trained people. The lay worker who can give baths, make beds, take temperatures and do much of the routine care of the patient will have to be trained and carefully prepared for his or her tasks in the care of the sick, but on no such elaborate scale as that of the professional nurse.

A "break-down" of services rendered to the patient during illness reveals many duties which might be performed by the "practical nurse" without danger to the patient. As an example — let us analyze the nursing care given during a typical day to a few representative patients in a general hospital, such as:

Mrs. L. — diagnosis, diabetic: T.P.R.; pre-breakfast care; breakfast; bath and change of linen; medications (and protamine zinc insulin); luncheon; trip to x-ray for special studies; rest period; visit and examination by staff doctor; afternoon nourishment; T.P.R.; afternoon care; medications; supper; last attention for the day.

Of the above list there are just two items which must actually be in the hands of a graduate nurse or of a student nurse under supervision, and they are the two items during the day (totalling perhaps fifteen minutes) when medication is given to this patient. All the rest of the care given her might just as well and quite as safely be given by a trained worker. The exception is, of course, expert observation.

Another example is: Mrs. V. — fifth day post-partum; nursing care much as outlined above, with the following exceptions: with morning bath, breast care; with bed pans, perineal care; babe to breast every four hours. The care of this patient, with the exception of the noted items, may be done by a trained worker. In fact perineal care is now being introduced as part of the regular technique to be taught volunteer Red Cross Nurses Aides in the United States. The daily

inspection of breasts, fundus of the uterus and lochia is part of the duty of the head nurse, while the routine care may be delegated to others.

On the other hand, let us consider the care required by Mr. C. B. — first day post-operative prostatectomy. Proper care of this patient includes watching drainage for bleeding and pulse for shock; irrigation of tubes; careful check on intake and output with forcing of special fluids; assistance given to doctor in redressings, administration of nursing measures and narcotics for pain; encouragement given patient during period of depression following operation. Most of these duties could not be delegated to an untrained worker. This is a sick patient who requires skilled nursing care, and whose symptoms may indicate changes in his condition, which anyone less well trained than a nurse could not be expected to see.

But what happens? In many cases all three of these patients are provided (at great difficulty by the hospital) with equal amounts of care by the professional nurse with the result that the really ill patient is neglected, while the less ill patients are waited on by persons whose time should go to the care of the really sick.

In hospitals with sufficient registered nurse staff, adequate supervision of the trained worker is feasible. In the home it may not be quite so simple. If the patient receiving home care required only part-time services of a professional nurse, this could be arranged on an hourly basis with the trained worker remaining in the home to take care of the more simple duties.

This raises the question as to why practical nurses are so frequently requested for home care. When the patient is the homemaker, there are homemaking duties to be performed. Both the professional and non-professional groups have frequently reported that these home-making duties are required of

them. It is interesting to recall that in the Weir Survey Report (1932) it was revealed that 85 per cent of registered nurses giving nursing care in homes expressed a willingness to perform these light home-making duties. There have been, however, many instances of the home-making demands exceeding the point of reason and interfering with the nursing care needed by the patient. If the home-making tasks are heavy and the services of a housekeeper are required, it might be possible to meet this need through a visiting housekeeper service, with nursing care arranged on an hourly basis. The hours of service provided at the present time by the group are in excess of what could reasonably be expected of any human being. There is room for reform in the practice of employing women for twelve, fourteen, sixteen and twenty hours daily, and an exposure should be made of the extent to which the public exploits this group. Long hours of service in the home in an occupation which is exacting and arduous are not compatible with the efficiency and health of the worker. There could be no justification for the practice of undermining the health of one group in an effort to restore the health of those already suffering from illness.

There would seem, too, to be sufficient evidence to indicate that the practical nurse is called frequently when the services of a fully trained nurse are required by the patient and when the family engaging her could well afford the best service available.

To an undetermined extent, physicians are asking this practical nurse group to perform certain procedures which can only safely be undertaken by the fully qualified nurse. Increased hospital expansion and the establishment of some form of health insurance should make it possible for acutely ill patients to receive hospital care. The professional and non-professional worker must be adequately protected so that in the minds of the public there will be no confusion

between nursing needs and housekeeper shortage.

Turning now to the subject of preparation for the practical nurse. In Great Britain and in the United States the concensus amongst those who have been concerned with drafting legislation for the subsidiary worker would seem to be that training and experience should not be given in hospitals where a professional school of nursing already exists; that this training and experience might be given in hospitals that do not conduct a professional school of nursing, where such hospitals are willing to provide qualified classroom and ward teachers and adequate equipment for the classroom; but there seems to be general agreement that it would be more advisable to establish a central school for this purpose. Those who have had preparation for and experience in the field of nurse education admit quite frankly that it is most ill-advised to attempt to train two types of workers in the same institution.

Then, too, in some instances there might be a tendency on the part of the hospital to enrol student-subsidiary workers in large numbers without regard for a desirable ratio of supervisors to students, so that teaching and supervision might be negligible and patient wellbeing jeopardized. Added to this, large numbers of workers would be turned out yearly without any guarantee of placement. The hospitals might not be interested in these workers as soon as they were ready to be placed on a salary basis.

A central school for the training of subsidiary workers offers many advantages, some of which may be enumerated:

- 1. The development of standardized techniques built upon the principles which underlie good nursing care.
- 2. An opportunity to develop group ideals and good working relationships with other workers in the medical and nursing fields.

- 3. An awareness that the school is conducted primarily as an educational project and not as a means of providing direct hospital service.
- 4. Closer supervision of students and a better understanding of student needs.
- 5. Opportunities for developing the type of rotation in these hospitals selected for clinical experience according to the level of maturity and aptitude of the student.
- 6. An opportunity to assist the student, when she graduates, to find that particular field of activity, or type of work, for which she is best suited.
- 7. Greater opportunity for personnel work with the students.
- 8. The impartial reviewing of reports from hospitals providing clinical experience.

Clinical experience in general hospitals with an all graduate staff is desirable. In one province where an experiment in training practical nurses was carried out, several small rural hospitals were selected. The instructor, who had conducted the central school, arranged for and assigned the students for their clinical experience. She also carried out a supervisory program by paying periodic visits to each hospital where students had been placed. Conferences with the nursing staff and students were found to be mutually beneficial.

This type of experience may not be possible or practical in all situations. An alternative plan, which merits consideration, is that of utilizing convalescent hospitals, hospitals for the chronically ill, and last but by no means least, the tuberculosis sanatoria. The latter offers an excellent experience in medical nursing and, under normal conditions, the quality of nursing care given to patients in tuberculosis sanatoria is, in the opinion of those competent to judge, of a superior quality.

The areas of service for the practical nurse or trained worker include: (1) hospitals, sanatoria and nursing homes, under the direct supervision of registered nurses; (2) in private homes, where to a limited extent they may be under the supervision of visiting nurse

service, city and provincial nursing service, with all-over direction and supervision by a provincial supervisor appointed under legislation.

It is suggested that a record of service rendered and duties performed for the patient be kept by the licensed subsidiary worker and this record placed on file with the provincial supervisor as each assignment is completed. A similar record should be available from each type of hospital engaging licensed subsidiary workers.

While the licensing of these workers would be carried out by the agency vested with that authority, the registration and placement of these workers should be the responsibility of the nurse placement bureaux.

In conclusion, I will summarize the ideas presented by Miss Fidler in her

paper on "The Preparation for Professional Nursing". She has suggested plans for the preparation of two types of professional nurse, plus the subsidiary nursing group:

The clinical or bedside nurse, who would be required to have Junior Matriculation and who, having been prepared in two years, would have professional status and be eligible for registration.

The teaching group who, being required to have Senior Matriculation, would be prepared in four years for more advanced service. This group would probably graduate with a degree in nursing.

I have, therefore, actually placed before you three types of nurses, all of whom would seem to be needed, if the nursing service requirements of the community as a whole are to be adequately met.

Pleased to Meet You

Perhaps every other professional group has as frequent meetings as we do but it is doubtful if any have more. Starting with staff conferences, nurses are continually either going to or just coming from a meeting. Autumn, winter and spring they assemble in committees, in local associations, in annual conventions. Most of the business at these meetings is conducted in quick order with very little dispute or controversy. Usually, the business session over, the nurses settle down in reasonable comfort to enjoy a guest speaker who brings them the latest word in new medical treatments, an educational symposium or plain, carefree entertainment. The high moment of the meeting, the release from tension comes when the redolent odour of coffee drifts over the assembly and refreshments are served. Then pentup tongues which have been curiously hushed are busy in pleasant conversation. Nurses like meetings.

For six weeks this past spring, it was our privilege to attend a few dozen of those meetings in six provinces from the Pacific to the Atlantic. We were there as the guest speaker and on each occasion our talk was on the same topic the Journal of the Canadian Nurses Association, of the nurses of Canada. The response to all of these numerous contacts was so heartening, so full of interest and resulted in so many new subscribers for the Journal it seemed appropriate to give a brief accounting in order that these scattered groups might realize the mutual pleasure so widely shared. Perhaps as never before hundreds upon hundreds of nurses in Canada realize that this magazine, The Canadian Nurse, is their personal responsibility. They know that it can only be as good as the material that they prepare in the form of articles can make it. They understand that each has a share in interesting others in the *Journal*, to read, to criticize its contents, to help to make it the best nursing magazine it is possible to produce. For all of these contacts, for the splendid support which has been assured, our thanks.

There were several interesting features on the lighter side which deserve some special mention. Her embarrassment when the editor drew her own ticket at an alumnae raffle in British Columbia; the original tribute, beautifully penned as an illuminated address by a clever Sister in Saskatchewan; the fresh lobster on the half shell in Nova Scotia; the thrill of the swift progress from point

to point by air travel; the beautiful corsages; the generous co-operation of provincial executive secretaries and *Canadian Nurse* conveners — all of these and many other incidents too numerous to mention made the trips memorable.

Many areas have not yet been visited. Plans are being made to attend as many as possible of the annual meetings of the Ontario district associations. Other areas will be visited as the occasions are presented. In the meantime, local representatives all over Canada are co-operating to make our Journal, The Canadian Nurse, worthy of its proud heritage. It was a pleasure to meet with so many, many nurses. Thank you for inviting us to come again.

-M.E.K.

Treatment of Venereal Diseases Revolutionized

The newest development in the venereal disease control program lies in the rapid treatment of both gonorrhea and syphilis cases. The United States Public Health Service recommends that gonorrhea cases be hospitalized for twenty-one hours, treated with penicillin and released as cured.

In syphilis it is proposed to treat cases at the hospital for a period of eight days, following which they are released as cured with instructions for follow-up being given. It is proposed to combine the use of penicillin, arsenic and bismuth in this eight-day treatment. It is stated that this method is relatively non-toxic and causes few undesirable reactions. It seems to be the best method for the mass treatment of cases of early syphilis and its use has been recommended to various local health departments.

-California's Health

National Immunization Week

National Immunization Week, sponsored by the Health League of Canada in cooperation with health departments, will be held this year from September 30 to October 6. The object of the week's observance is to draw attention to the fact that every Canadian child should be and can be protected against smallpox, diphtheria, whooping cough and scarlet fever.

In 1944 there were 3,211 cases of diphtheria and 13,382 cases of whooping cough.

Dominion Bureau of Statistics 1944 fatality figures were incomplete at the time of writing, but for the first nine months of the year there were 168 deaths attributed to diphtheria and 209 to whooping cough. Thus it can readily be seen that this common disease of childhood is a killer.

Immunization against diphtheria can be obtained through use of harmless but effective toxoid.

-Health League of Canada

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses
Association

The Future of the Nurse in Public Health

M. R. MACDONALD, M.D., D.P.H.

Today when social security is a very familiar topic of conversation for almost everyone, in almost every land, a person in the public health field would like very much to peer into the future and attempt to see just what developments in this particular field are going to take place. Great should be the results of all this invigorating interest in the social, health and welfare problems of our nation. I am sure most nurses would like to know the ultimate position of the nursing profession, in such a broad and challenging program.

Being unable to see the future, all we can do is attempt to envision it and conjecture as to the potential developments; that person who does not think that these developments are to be of major importance is indeed not very imaginative. The nursing profession will have to take bold steps and will have to take a very active part in this development if it is to maintain its position in the forefront of health activities. It must chart its course not as individuals but as an influential and capable body of professional workers whose responsibility is great.

In the public health field, the need for additional nurses is recognized under the present program, and how much greater will be the need in an expanded program? Public health activities to a large extent revolves about the public health nurses. The success or failure of programs may depend directly upon the nurses who are vested with the responsibility of doing the work in the field. For this reason, great care will have to be exercised in the selection, the training and the development of public health nurses.

Can the hospital of the future or its staff of nurses, or the private duty nurses remain aloof from these developments? Can they continue to leave the interest in work pertaining to the public health entirely in the hands of a comparatively small body of specialized workers? It is very doubtful. The field is large enough and important enough for the whole nursing profession and if expansion is to be of the magnitude envisioned by many today, then it will be very difficult for any nurse in any hospital or in private duty to remain aloof.

I envision the hospital of the future as a community health centre that will not only be responsible for therapeutic or curative medicine but will indeed pay as much attention to the preventive aspect of medicine. It is hardly conceivable that hospitals can remain behind in an expansive and popular program that has for its objective the maintenance of a positive health among the people of the community which it serves.

The position of a hospital in such a program will be only as good or as use-

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ful as the interest and energy displayed in an expanding public health program by the superintendent and the nursing and medical staffs. It will behoove this personnel to acquire a broad and sympathetic understanding of the many and varied public health problems, because only if they are acquainted with the problems can they be of much practical use in the solving of them. Indeed at the present time many of the lay members of hospital boards are ahead of the medical and nursing personnel in their approach and their knowledge of problems that are receiving the attention of public health workers across Canada.

If the comparatively small band of public health nurses is to be augmented and increased in size, then it becomes part of the training hospitals' responsibilities to interest and teach the young nurses-in-training so that they will acquire a better and more complete understanding of public health work. This, of course, will be in contrast to present day standards where, at best, in the majority of teaching hospitals a smattering only of preventive medicine is provided the nurse during her period of training. To insure that the public health worker is competent and interested in her work, much will depend upon the direction and encouragement given her by those responsible for her nursing education.

The potential public health nurse will ask and will want a fairly complete picture of her duties and responsibilities as a public health nurse. Underpaid and overworked public health nursing staffs will not act as a drawing card for the recent graduate. They will have to be shown that they are not to be regarded as pioneers or crusaders to the degree that they were not so long ago and devote their time and talent to work which may or may not be appreciated. That day in public health is gone. The work must be made attractive and the volume of work should be no more than a person can handle with satisfaction, contentment and for a remuneration which

will assure her of a standard of living comparable to the years of preparation and the maintenance of a status of life in the community that is expected of her. On the other hand, the nurse entering the field of public health should have an appreciation of what is expected of her. She should remember that public health still requires a lot of missionary zeal. She must remember that her responsibilities are great and that she has much to contribute to the success of any public health program. There is no place in the public health field for the shiftless, arrogant or selfish worker. As a part of an organization she must be able to assume her role working in unison and harmony with the other members of the organization. Her potentialities for contribution to the general welfare and success of a program are almost unlimited.

In earlier days of development of public health techniques, the public health nurse did "specialized work", that is, she confined her efforts to a limited field or to a single problem, such as tuberculosis. This did not prove to be satisfactory in the majority of places for a number of reasons. This led to a variety of nurses in a community doing specialized work and able only to devote their time to the particular problem to which they were assigned and in many cases they lost sight of the general picture. Also, patients and their families were subjected to the visits of several, rather than one nurse, and this proved to be a source of annoyance as well as being impractical.

Today we find the pendulum is swinging in the other direction and most nurses are doing a generalized service in public health. This tends to build up the confidence of the public in the nurse. Likewise, it reacts favourably for the nurses, as they have a more interesting variety of work and it makes the approach to a family much easier. Recently in the control of venereal diseases, specialized workers who have been des-

cribed as non-medical epidemiological workers have entered the public health field, and along with these non-medical workers have been nurses lacking a public health training, but with the few months training given to non-medical epidemiological workers. Our experience in this regard has been good and much excellent work has been done, but one wonders if this work could not be done by the nurse in the generalized field. Personally, I would say "yes". While the specialized worker may have or develop certain attributes which enable her to show a marked progress in her particular field, yet the determining factor is a question of time available to be devoted to a particular duty. The generalized public health nurses have a better and less auspicious approach to a family or person; they may go seeking or interviewing a person for a variety of reasons, but once the nurse in the specialized field undertakes to locate or interview a person, immediately eves are lifted and opinions expressed. The "V.D. nurse" or the "TB nurse" was to see so and so.

Regarding special tact or diplomacy needed for venereal disease work - this I believe is a myth, and the farther we go in the control of these diseases, the more it will be proved to be so. Our nurses, like our doctors, and like the public in general, have been very reluctant to speak of syphilis or gonorrhea, or to have very much to do with persons afflicted with either disease. Once this barrier is broken down and greater progress is made, it is reasonable to assume that the generalized public health nurse, who has the necessary tact to make a good approach to a family regarding tuberculosis contacts or for other reasons, will be just as tactful and will have as good a method of approach in regard to the venereal diseases. Our nurses need to be educated regarding these diseases as much as other workers in the field. A complete understanding of the problem and its control or cure will serve to build up their confidence to the degree where

venereal disease contacts are no more difficult to deal with than other persons requiring care.

The public health nurse is a health educator and is probably in the best position to do the educating. In order to be successful, much will depend upon her scholastic training, her hospital training and her public health training. In hospitals, particularly, I feel that nurses are not impressed sufficiently with the responsibilities which they should discharge once they are graduate nurses. Whether they later enter the public health field or not, they are health educators for the rest of their lives for, because they are nurses, people seek them out for information pertaining to health matters. If this information is given, but is not correct or is not explained fully, incalculable harm may be done, which reflects upon the nursing profession as a whole. It is far better for a nurse to refuse to answer questions than to give an answer that is incorrect or biased and to mislead people who readily accept her word as authoritative.

A recent innovation in the public health field is the "Health Educator" whose duty it is to direct and supervise the health education of the public. Whether this form of health education will prove to be practical or not is a moot question, but the public health nurse will remain alone as the person who is best able and is in the most desirable position to explain and demonstrate what is essential for the individual with whose care she is entrusted. The "Health Educator" may certainly occupy a role of supervision and direction of education.

In other fields, such as nutrition and physical fitness, private nurses and public health nurses will have to share a responsibility, if these programs are to be successful. In some instances it will mean no more than displaying an interest; in others it will mean taking an active part and the success or failure of such a program may very well depend upon the degree of acceptance and en-

thusiasm with which they are received by the great body of nurses.

With the forward march in "Social Legislation and Social Security", a greater liaison and a greater degree of cooperation between health and the different welfare agencies will have to be worked out, so that we will not revert to the old problem of duplication of visits. A whole program of social, health and welfare activities may very well fail because of the little things which will

break down public confidence in our workers. An otherwise well-intentioned and efficient program may fail because of lack of co-ordination and direction.

Indeed the future will provide a challenge to the nursing profession, an active energy and interest will be needed, a broadening of viewpoints and a willingness to co-operate will have to be developed if nurses are to maintain the enviable position of esteem and respect in which they are rightly regarded by an appreciative public.

Beware of Poison Ivy

Each year as amateur gardeners busy themselves in their vegetable or flower gardens, or as hikers or campers get out into the fields and woods, a fresh crop of sufferers from plant dermatoses develops. Symptoms may vary in degree from a mild erythema to a vesiculative dermatitis. The eruption usually occurs on the face but the neck, hands, ankles, knees and genitals may be affected. An acute dermatitis of the face, associated with marked edema of the eves. usually indicates that the patient has been in contact with the oils, pollens or even the leaves of some plant. The dermatitis may last for several weeks, sometimes until the frost kills the offending plants.

Ivy poisoning is the most common form of plant dermatitis. The offending agent is a vine or low bush found widely throughout Canada, in moist soil and dry, in the woods and in open areas. It may be recognized by the three shiny, dark green tapering leaflets, by their reddish tinge in autumn and by the whitish waxy berries. Closely akin to the ivy is poison oak, the leaves of which are blunter, more rounded. Equally poisonous, is the poison sumac which grows in swampy places and can be distinguished from the harmless variety by the white berries instead of red and by the nonsticky fuzz covering the stems. Since it is estimated that one person in every eighteen is susceptible to the poisonous sap or oils which these plants exude, their immediate recognition is important.

The clinical picture most frequently seen

is an acute vesicular dermatitis on the exposed areas of the skin chiefly, though the irritation may spread to any part. Intense itching and burning are common symptoms. Constitutional symptoms are seen in rare cases of great severity. The incubation period varies from twelve hours to seven days.

Those who have been exposed to this plant poison should take a hot bath immediately, lathering the body well with a rich suds to dissolve the oils. The nails should be scrubbed and thoroughly cleaned with an orangewood stick to remove every vestige of resin. All the clothing worn at the time of exposure should be dry cleaned. Soothing alkaline cold creams may be applied to the skin. Creams containing 10 per cent sodium perborate have been found useful as prophylactic agents. Sponging the areas with alcohol may also be effective.

When the eruption occurs, creams or ointments are contra-indicated since the resin is oil-soluble and the irritation may be further spread. In the acute inflammatory stage, continuous wet boric compresses or applications of 1:5000 potassium permanganate are soothing. After twenty-four hours calamine and zinc oxide lotion will bring relief, applied cold every hour, more often if necessary. In some cases, antigen injections may bring relief. The oily preparation of the antigen is less painful than the alcoholic but not so effective. Desensitization is problematical. The safest preventive is to know and avoid the offerding agents.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A.

A Challenge to Head Nurses

FLORENCE M. WILSON

Gradually, in the field of nursing education, there has arisen a method of teaching student nurses known as clinical instruction. It is generally recognized that the word "clinical" refers to the patient — his disease, his treatment, his nursing care, or his prognosis, and thus in a school of nursing clinical teaching is the instruction of the student nurse with reference to the patient. In a slightly narrower sense, clinical teaching is carried out on the ward, in other words, while the student is caring for the patient.

Probably no one would deny the tremendous advantage to the student nurse, and ultimately to the patient, of organized ward teaching. However nurses who are not instructors are inclined to feel that teaching is a specialized branch of nursing which they know little or nothing about, and as a result they have decided to leave all the clinical teaching to the ward supervisor or the clinical instructor. This article is written for head nurses and general duty nurses in the earnest hope that it will awaken in them a realization of the fact that they are all indispensable to any ward teaching program.

To emphasize the value of clinical teaching, Wayland in "The Hospital Head Nurse" states: "No more dynamic and favorable learning situation is to be found in the total educational program

than that offered by the actual care of patients, nor one that provides for more integrated learning. Without competent educational direction, however, the student in the midst of a wealth of learning opportunities may not 'see the woods for the trees', or she may be so driven to get the work done that she fails to learn from her experience, Clinical practice provides opportunities for learning the art of nursing, but the art will be learned only if good nursing is attentively and intelligently practised in the mit, and if the head nurse utilizes her unique opportunity of teaching the student, as she repeatedly and progressively practices not the manual processes alone, but the whole art of nursing."

The more organized forms of clinical teaching, such as the nursing clinic and the bedside demonstration, are generally recognized, but this article deals only with methods of clinical instruction which are going on all the time, but which are not recognized as formal instruction, and methods of teaching which could be used with very little adjustment in the daily routine. The following methods are included: precept and example; impromtu teaching; the orientation conference; the morning circle; the individual conference; supervision of procedures.

Precept and Example:

Every graduate nurse is a teacher

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whether or not she wants to be or thinks she is. Think of the graduate nurse in a school of nursing - she is the goal toward which every student nurse is striving; she represents the ultimate, the ideal of accomplishment. All of us are inclined unconsciously to imitate those who are senior to us, and certainly much of what the student in the school of nursing learns, whether it is good or bad, she learns from the var ous graduate nurses with whom she works. Everything about the graduate nurse is closely scrutinized by the student nurse: her appearance, her methods of dealing with patients and personnel, and her nursing techniques, to mention a few. At all times this type of teaching of the student nurse is going on. We have all seen the transformation in quality of work done by a group of students when they are placed in a situation where the head nurse or another graduate nurse on the ward sets a splendid example for them. On the other hand, students in contact with a careless, muddling, or boisterous type of graduate nurse will develop many of her bad habits, and some of them will never lose those habits. Before any teaching in a school of nursing, be it classroom or ward teaching, is going to have a fair chance of producing the type of student nurse desired, it falls upon every graduate nurse in the institution to realize what an important part she is playing



Impromptu teaching at the patient's bedside.

in the moulding of each student with whom she comes in contact.

Impromtu Teaching:

A second method of teaching which could go on most of the time on the ward may be called impromtu teaching. Wayland says: "Indeed, much of the most effective and worthwhile teaching in the whole school program is unhead nurse teaching." This type of teaching means exactly what the name implies — the situation arises, and the head nurse takes advantage of it to bring some point to the attention of the student. For example - what student would forget the symptoms and treatment of acute cardiac decompensation if someone took the time to do a little impromtu teaching while she was admitting the patient, and carrying out the doctor's first orders? Much impromtu teaching may be done at the patient's bedside while the student is giving bedside care — for example — assistance with the pillows of a patient who has had a thyroidectomy, or assistance in making a very ill patient comfortable.

A group of students may be taught in this way also. If an unusual situation suddenly arises on the ward, its significance may be lost to the students, if no one takes time to give them some explanation and direction in their observations. One of the best examples is the admission of a patient in diabetic coma. To wait two or three days before discussing such a patient with the students caring for him means that much of the value of that teaching situation has been lost, because by that time the patient will probably be up and around the ward, and the students will have forgotten a great deal about the picture he presented on admission.

There are two points about this type of teaching which should be stressed: First, the head nurse must be on the alert for such situations — many good opportunities are probably lost. Secondly, where impromptu teaching is done at the

patient's bedside, the student must not be made to feel that her work is being criticized, for she will immediately be on the defensive, which is a poor beginning for teaching. The teaching must be done in such a manner that the student feels she is being taught and not "snoopervised."

The Orientation Conference:

"The term 'to orient' means to get one's bearings, to see and understand relationships clearly." (Wayland).

The orientation conference should take place on the morning of the student's first day in the new department, and should occupy almost an hour. If possible, a group of students should be given this instruction at one time, thereby saving the head nurse's time. Actually orientation cannot be accomplished in one conference only, but will require three or four such periods during the student's first week on the ward. Although this type of teaching may appear to be very time-consuming, it pays dividends in that the student knows what she is doing, and understands her objectives much more clearly, and thus is able to render more satisfactory service; she will find her entire experience better from her own learning point of view.

The material discussed at the orientation conference would naturally vary with the experience of the individual student. In the main, such things as ward geography, ward routines, special treatments, and so on, are discussed. As part of the first conference, the new student is introduced to the other ward personnel, and to the patients she is to care for particularly, and is given detailed instructions about her own work. It seems advisable to leave a discussion of the diagnoses, etc., of all the patients on the ward to a second or third conference when the student has her bearings a little hetter.

The orientation conference should be conducted by the head nurse, because she, better than anyone else, knows all



The morning circle.

about her ward. In making a plea for adequate orientation to a department, one feels that many errors which a student makes are the result of her not knowing what she should have done because no one took the time to tell her, and much of the time she may waste is the result of not knowing where to find things or of not having been informed of ward practices.

The Morning Circle:

Quoting from Jensen: "The daily morning conference, which all nurses, graduates and students, on any ward attend offers a great opportunity for teaching. It is the time when the night nurse in charge of the ward or division gives her report of all the patients' conditions during the night, so that the day staff may be prepared to give better nursing care."

This conference should take place at the beginning of the day, usually at 7 a.m., and should not last longer than fifteen to twenty minutes. The report is read to the group by the night nurse, during which time the head nurse should ask questions of interest to the group. Following the reading of the report there is a discussion on newly admitted patients, patients who are to have operations, special tests or treatments, and outstanding changes in patients' conditions, diets, etc. The head nurse may have some point of general interest to bring to the attention of the nursing staff

or occasionally she may use part of this period to draw to the attention of the nursing staff any laxity which their own work has shown. Nurses are always given an opportunity to ask questions during any part of this conference, and are encouraged to mention any points which are of interest to everyone. Following this discussion assignments of work are given and, where necessary, explanations are made.

The value of a properly conducted morning circle cannot be too greatly stressed. The nursing staff will have a greater interest in all the patients and will be able to start their day's work feeling that they understand what is going on.

The Individual Conference:

As the term implies, this type of teaching is a discussion between the head nurse and the student alone. It is absolutely essential during every student's experience in a department, and each student should have the privilege of several such conferences.

The general purpose of such a conference is to direct the student in her work, to find out her aims and ambitions, and to give her advice where necessary. To begin with, a good relationship must be established between the student and instructor, by keeping the discussion on the level of instruction rather than criticism, and by putting the



The orientation conference.

student sufficiently at ease, so that she will not be embarrassed about showing her ignorance of the special problems of that ward. The discussion must be held in a place where there will be no interruption, and the length of time obviously would vary with the problem at hand.

Routine conferences which should be held with each student would be concerned with her progress in the department. A final conference would be helpful in summing up the type of work she has done, commending her where she has excelled, and directing her in solving any problems which she may have. Students who are consistently below average would probably have more individual conferences with the head nurse, who would do all possible to find out why the student's work was not acceptable. and thus attempt to improve its quality. Other students may have personal difficulties, or difficulties peculiar to that situation (e.g. O.R.) which an individual conference would do much to solve.

Those in charge of directing students in a department must make the student feel free to seek an interview. If at the time the student seeks advice the head nurse is busy, she should arrange another period which would be more suitable.

Wayland, in discussing supervision through individual conference, states: "For the head nurse, it is the moment of all moments at which she can learn most about the student and can exert her own personal influence upon the student's personal and professional growth to the fullest extent - a moment of great challenge to a real teacher. For the student, it is the moment when she is free to avail herself of the head nurse's help with the problems of learning and personal adjustment. The benefits to both head nurse and student will come about only if the student feels that the head nurse is sincere in her desire to help and is fair in her dealings."

Supervision of Procedures:

In most schools of nursing, the students are required to carry out some

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procedures for the first time under supervision — for example — catheterization, hypodermic injection, vaginal douche, etc. The alert head nurse will be certain to make this a good learning experience for the student.

Before doing the procedure, the student should be required to review what teaching she previously has had on the subject — this would include definition, purposes, necessary articles, procedure, and precautions. Where necessary, the instructor will supplement the student's information.

During the actual carrying out of the procedure, the instructor should assist in such a manner that the student will carry out the procedure herself, but will be more at ease than would be the case if she were being closely scrutinized.

Following the procedure a short discussion is held on the type of work which the student has done, and any questions which she may have are answered.

As was stated in the beginning, this article has been written for graduate

nurses working with student nurses in an effort to show how much influence they have on the type of learning which the student receives. Surely you will all agree with Anna Taylor that "ward instruction is basic if adequate nursing care is to be practised." An attempt has been made to show that there are certain means by which the graduates in a nospital may contribute to a student's learning experience, in fact are contributing at all times, even though they may not be part of the teaching staff. The contribution which they make is immeasurably important to the student nurse, the patient, and the smooth functioning of the entire institution.

It has been said that of all avenues open to the registered nurse, that of head nurseship is the most satisfying. To combine the satisfactory administration of a ward with the contribution to the education of student nurses is the task you have set yourself in becoming a head nurse. The challenge is there — seize the opportunity!

S.R.N.A. Handicraft and Play Therapy Exhibit

The handicraft and play therapy exhibit, prepared by Miss Grace Giles, created much interest at the recent annual meeting of the Saskatchewan Registered Nurses Association. Stimulated by such articles as "Necessary Ingredients", which appeared in the February issue of The Canadian Nurse, it was decided that the S.R.N.A. convention exhibit this year should centre around Handicrafts and Play Therapy for Children. A list of arts and hobbies was circularized among nurses and people interested in arts and crafts, inviting them to loan articles for the exhibit. The enthusiastic response resulted in a beautiful and interesting display of handicrafts.

In addition to lovely examples of all the commoner forms of handwork, there was weaving, leathercraft, doll furniture — delicate and complete to the smallest cu-

shion, ornaments, wood carving, modelling, jewellery and ornaments of nuts, pine cones, felt and leather. A sewing basket woven from dyed wheat straw drew much admiration, as did the book-ends, vases, bowls and other pieces of pottery made from Saskatchewan clay. Under the caption "Book Repair", all the steps in rebinding used books were shown. Inner facings of birchbark and bindings of overalling were some of the unusual materials used for this work. In another section an intriguing little flowered hat reposed in its transparent hat box, made of old x-ray film. Beautiful lino-prints, colourful posters, soap carving, cunning rag-bag toys, with other articles too numerous to mention, made a unique display.

A very fine collection of stamps, samples of weaving and a handmade copper lampshade formed the contribution from one nurse "on duty" in one of our smaller hospitals. In addition to seeing the possibilities of hobbies the nurses received information on where to obtain materials, patterns and directions, and approximate costs. A graduate nurse with years of experience in craft work gave an illustrated talk on several of the crafts represented.

One of the pleasantest incidents connected with the exhibit was the "preview" held for the Sanatorium patients on the evening before the convention. Patients were delighted to recognize work done in their own hospital and to gain a new idea of the many possibilities in handicrafts. There were even some who were wheeled about the tables on stretchers. An exquisitely modelled dog had come from the hands of a little Sister, whose face shone with hap-

piness as her carriage was moved up and down the aisles.

It was not solely to introduce nurses to the joys of hobbies that the exhibit was planned. There is a real need for trained Occupational Therapists in our hospitals and to widen interest and increase understanding of the work, an additional display was arranged. The Canadian National Association of Occupational Therapists kindly loaned a number of posters and photographs describing and illustrating Occupational Therapy. The nurses were much interested and hope to promote the development of this important branch of therapy. An excellent article on "Occupational Therapy for Children" with some accompanying pictures from the Hospital for Sick Children. Toronto, was greatly appreciated.

Liven Up Your Meetings

Three very useful little books have been received recently. The first, "Planning your Meeting" by Ruth Haller, price 50 cents, discusses practical points to remember in preparing for various kinds of meetings. Such forms as panel discussions, symposia, round tables are explained very simply. Methods for "dressing up" meetings to give variety are outlined. The second handbook has the intriguing title of "How to Make a Speech and Enjoy It" by Helen Partridge, price 75 cents. So many nurses when asked to give a talk, shudder and get stage fright. "Treat your stage fright as the asset it is. Beforehand-nervousness charges your batteries. The more multitudinous your misgivings, the more you will be goaded into preparation and the better your speech will be". Explicit instructions are included on how to prepare the speech, what to wear, etc. The third booklet is a comprehensive outline of the "Rules of Order and Procedure for the Conduct of Public Meetings" by W. H. Fuller, price 15 cents. Here is parliamentary procedure in a nutshell. The officers and members of nurses' associations will find this information a valuable guide to the effective transaction of business.

The first two books may be procured from the National Publicity Council, 130 East 22nd St., New York City 10. The last booklet is published by N. A. MacEachern & Co. Ltd., 165 Elizabeth St., Toronto, Ont.

Recreation Conscious

A nation virile and active has no place for disease and attendant miseries. A nation of individuals interested in organized recreational programs has neither the time nor the inclination to take paths which lead to unhappiness. Therefore, there appears to be a definite place in Canada's life for the National Physical Fitness Act which is aimed at the promotion of the health and happiness of all the nation's citizens. Also, it appears that establishment of a Division of Physical Fitness and Recreation in the Saskatchewan Department of Public Health probably is the most constructive step so far in any implementation of the national act.

This provincial department organized a Saskatchewan Recreational Movement (SRM) and lit a fire which, in the words of the movement's official publication, Saskatchewan Recreation, is "sweeping the province". SRM hopes to interest every village, town and city in helping promote social, cultural, and athletic activities, enterprises and events for the nearly nine hundred thousand men, women, and children of the prairie province.

The Saskatchewan movement is said by Major Ian Eisenhardt, national director of Physical Fitness, to be "the most advanced provincial proposal to date".

-- Health News Service.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

A Word to the General Nursing Section

MABEL E. BROLIN

We are missing the boat . . . Having just returned from meeting nurses from all nursing groups, I realize with a pang that all is not well with our own

particular group.

We are the backbone of the nursing profession — we are the ones to whom the ultimate privilege is granted, that of nursing back to health, with our own hands, another human being. Ours is the happiness of receiving the thanks of a grateful patient. We are the ones to whom the sick turn, in pain, in sorrow or in joy. In our hands, in a very large measure, lies the fate of each patient's recovery. We are the human link in a strange white world which guides them back from pain and from death. We are indispensable . . . yet for some strange reason we have allowed people to slip into the error of regarding ours as an inferior position in the nursing world. Stranger still, we are allowing ourselves to acquiesce in that thought. We seem to have adopted a chip on the shoulder attitude to the other branches of the profession, in a vain effort to combat what has become an inferiority complex.

Administration is a very necessary part of our profession. Without it our nursing world would be a chaos instead of the well run machine we have the right to demand in order to do our own best work. It is a different type of work, that is all, not a better one. The person fitted for that type of work needs perhaps, a different personality to be as successful in her place as you are in yours. We are component parts, and must co-operate to achieve a successful whole. Let us remember that and avoid dissension.

We must get ourselves back on the road to happiness and service. I would say the first step on that road is to ask ourselves if the work we are doing is the work that we wish to do. If it is not, by all means seek some other branch of the service. I believe the primary desire on first entering the profession is to give personal service, but by allowing our status to appear inferior in the eyes of our profession we are sometimes ashamed to admit that there is where our real interest lies.

If your real happiness in your work is in administering personally to the sick, then I would say — get behind your Section's activities. Then by precept, well-chosen leadership, and by fullest participation in post-graduate education in our own field, let us guide ourselves back to our place in the sun and convince the profession as a whole and the world at large that there may be different branches of service but none better.

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Postwar Planning Activities

Contributed by

POSTWAR PLANNING COMMITTEE OF THE CANADIAN NURSES ASSOCIATION

Re-establishment Information

Although many nursing sisters will have set aside their uniforms before this is published we think perhaps some of the information contained here may be of interest and help to many who still are in uniform. The April issue of the Journal carried some suggestions about the nursing positions waiting for the nurses. In the July issue is a list of the university courses, hospital post-graduate courses and added experience courses which you will find very useful should you wish to do a bit of studying or brushing up before seeking work.

In the brochure prepared for the nursing sisters we have made reference to the various Acts which have been passed by the Federal Government to aid in the re-establishment in civilian life of all armed service personnel, and we think that all should be familiar with the content of these Acts.

The Post-Discharge Re-establishment Order (P.C. 331, January, 1945). "University Education (Undergraduate): In case any discharged person (a) has been regularly admitted to a university before his discharge, and resumes within one year and three months after discharge a course, academic or professional, interrupted by his service, or (b) becomes regularly admitted to a university and commences any such course within one year and three months after his discharge; a grant may be paid to such discharged person for any period during which he pursues such course, upon the terms and subject to the conditions" of the Act.

"University Education (Post-Graduate): Where any discharged person resumes or commences a post-graduate course, either academic or professional, in a university within one year and three months after discharge, or commences such a course as soon as may be after completing an undergraduate course commenced or resumed by him after discharge, or where such person, on account of ill health or other reason satisfactory to the Department, delays resumption or commencement of such course beyond such periods, and the Department, having considered such person's attainments and his course, deems it in the public interest that such discharged person should pursue such course, a grant may be paid to him upon the terms and subject to the conditions" of the Act.

"The scale of grants provides for payments of \$60 monthly to single men or women and \$80 monthly to a man and his wife when the ex-service man or woman is taking training or completing education."

The Veterans Insurance Act, 1944. Parliament has enacted legislation providing government insurance for veterans on discharge:

"1. One of the principal features of War Veterans Insurance is that, with very few exceptions, it is available at low cost, without medical examination.

2. Any ex-service man or woman is eligible.

3. The plans of insurance available are 10-payment Life, 15-payment Life, 20-payment Life, Life paid-up at 65 and Life paid-up at 85. Term and Endowment policies are not issued. The

insurance is of the non-participating type, that is, no dividends are paid.

- 4. Policies may be applied for in amounts ranging from \$500 to \$10,000.
- 5. After premiums have been paid for two full years, the policy may be surrendered for its Cash Surrender Value. There is no provision for loans against the policy.
- 6. Where the insured is married, the beneficiary must be the wife or husband or children, or both. If the veteran is single, the beneficiary must be the future wife or husband, with a parent, brother or sister named as a contingent beneficiary to receive the insurance money should the veteran die unmarried.
- 7. In addition to being free of occupational restrictions, the insurance is also free of restriction as to travel and residence.

Further information may be obtained from the nearest office of the Department of Veterans Affairs or by writing direct to the Superintendent of Veterans Insurance, Department of Veterans Affairs, Ottawa."

Reinstatement in Civil Employment Act, 1942.

One of the first Acts placed on the statute books looking towards re-establishment was the Reinstatement in Civil Employment Act. The main points in the new Regulations may be summarized briefly thus:

In the case of a person who immediately after discharge is delayed in returning to his or her former employment by reason of hospitalization or physical incapacity, any period of hospital treatment or incapacity may be counted as continuity of service for seniority, pension, and so forth, in the same way as is the period in the Armed Forces under the Act. (Sec. 4).

Where an employer's business is carried on in more than one establishment, and where an employee cannot reasonably be reinstated in the particular establishment in which he was last employed, the employer is required to reinstate the

applicant in one of his other establishments if it be reasonably practicable to do so, and if it has been the practice of the employer to transfer employees of the type of the applicant from one establishment to another (Sec. 6).

A person discharged from the Forces in Canada is allowed three months under the Act in which to claim his former employment-or four months if discharged overseas. The Regulations guarantee the applicant this interval between discharge and reinstatement, regardless of whether an employer may in the meantime offer the applicant an immediate return to his employment. It is felt that those discharged from the Forces may require a period of rest or reorientation, and should be free to have this rather than be obliged to return immediately to employment upon notification from the employer. (Sec. 7).

A discharged person, who requires time to recuperate from a physical or mental disability before returning to work, will be allowed to claim reinstatement during an additional period of six months — in other words, such a person may claim reinstatement within nine months if discharged in Canada, or ten months if discharged overseas. The effect of this section will be to safeguard for this extra period the rights of a man who returns in a handicapped condition. (Sec. 9).

Where an employer claims (under Sec. 4 (e) of the Act) that an applicant is not eligible for reinstatement since he was employed to take the place of an employee who had previously entered the Forces, the employer must prove that the applicant was employed directly or indirectly to take the place of the other employee and would not have been employed if the other employee had not left. (Sec. 10).

The Minister of Veterans Affairs has issued a booklet entitled "Back to Civil Life" which contains many suggestions and facts concerning discharge proce-

dure. This booklet includes information on many of the following topics: rehabilitation, reinstatement, post discharge re-establishment, rates of grants, university education, unemployment insurance benefits, treatment branch, pensions commission, list of Veterans Welfare offices.

Book Reviews

American Medical Practice in the Perspectives of a Century, by Bernhard J. Stern, Ph.D. 159 pages. Published by The Commonwealth Fund, 41 East 57th St., New York 22. Price \$1.50. Reviewed by Mary S. Mathewson, Assistant Director, McGill School for Graduate Nurses.

This monograph is the first in a series of studies being undertaken by the Committee on Medicine and the Changing Order of the New York Academy of Medicine. The main purpose of the series is to investigate the economic and social changes taking place now and those likely to occur in the immediate future and the probable effect of these changes on the various branches of medicine. It is also concerned with the preservation of the best in the art and science of medicine and of medical service to the public as well as the search for new ways and means for improvement and adjustment to meet changing conditions.

The first volume presents a broad historical picture of the changes in social and economic life in the United States during the past century and their influence on the development of medicine. The topics discussed include the expansion of the medical horizon, development of specialties, patient load, income of physicians, distribution of medical services, and the effect on civilian services of the entry of enormous numbers of physicians into the armed forces.

This interpretation provides insight into the origin of current problems in medical education and medical service. Such a perspective is essential to an understanding of the present situation and as a basis for intelligent planning of future action. The story closely parallels the general development in this country and is interesting, therefore, to those

who are concerned with the future of medicine and allied fields in Canada.

Future volumes will deal with hospitals, public health services, rural medicine, industrial medicine, prepayment and insurance plans, nursing, and dentistry.

The Woman Asks the Doctor, by Emil Novak, M.D., F.A.C.S. 130 pages. Published by The Williams & Wilkins Co., Baltimore. Canadian agents: University of Toronto Press, Toronto. Price in Canada \$2.00.

This small, compact volume of fifteen chapters, written in a clearly understandable style for the laywoman, contains the quieting answers to the many vague questions that continually arise in the minds of women of all ages.

The chapters on menstruation should be of particular interest and once and for all should clarify the confused ideas that exist regarding this female phenomenon. That part devoted to the "change of life" should be read by every woman if only to destroy the needless fears too often planted by well meaning and over eager friends. The sections on the reproductive organs and sex life of the female, written in non-technical terms, answer the many questions that doctors are continually faced with by their women patients. The vital difference between cancer and tumours is dealt with. The nurse realizes that, too often, these two conditions are regarded in a confused way as "practically the same thing".

This is an inexpensive book that the nurse could well profit by reading herself as well as recommending to her patients.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

Labour Relations Committee

In the report of the Labour Relations Committee submitted to the last meeting of the Executive Committee in October, 1944, the committee reported that its work was concerned with (1) methods of collective bargaining for nurses; (2) the relationship of nurses with trade unions; (3) interest in Dominion and Provincial labour department regulations that affect or may affect nurses.

Collective Bargaining for Nurses

Since the last meeting of the Executive, further consideration was given to the resolution passed by the Executive Committee at their meeting in November, 1943, namely, "That the National and Provincial Associations should be the bargaining agent for nurses".

The Wartime Labour Regulations Act, P.C. 1003, which the Dominion Government passed by Order-in-Council in February, 1944, preserves for all employees the right to bargain collectively under certain prescribed conditions. These regulations, in common with most provincial legislation in reference to collective bargaining where such exists, state definitely that a bargaining agreement must be between employers and employees.

An employer is defined as a person employed in a confidential capacity, or one having the authority to employ or discharge employees. This raised the question — Could Provincial Nurses Associations which have an employer, employee membership, be the legal bargaining agent for nurses? As this ques-

tion was subject to provincial interpretation, it was referred to the Provincial Associations for study with a strong recommendation that they secure legal advice.

In the majority of provinces, Provincial Labour Relations committees were set up and to date we have heard from six provinces, giving the following information: Five provinces — Nova Scotia, New Brunswick, Manitoba, Saskatchewan and Alberta — have secured legal advice and the decision has been either that it is not legally possible or not expedient for Provincial Nurses Associations to act as bargaining agents for nurses. Quebec is still exploring the possibility in relation to the Quebec Collective Agreement Act.

Contact was made with other professional groups, notably the Corporation of Professional Engineers. This organization, with other professional organizations combined under the name of the Canadian Association of Scientific Workers, explored, as reported in October, 1944, the possibility of securing separate legislation for professional workers in reference to collective bargaining. So far, this has not been granted and they report that the chances of obtaining such a separate code are very meagre.

The Canadian Association of Scientific Workers made an exhaustive survey of the possibility of their professional associations conducting bargaining negotiations for their members. The conclusion was that as all professional associations included in their membership, both employers and employees, they were unfit so to act. They then decided

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that suitable employees organizations would have to be set up as separate new bodies, unaffiliated with any existing professional association or society. This has resulted in Quebec in the forming of the Quebec Federation of Professional Employees in Applied Science and Research, and in Ontario in a separate organization for professional engineers who are employees. The advisability of a separate provincial organization of nurse employees presents difficulties and dangers and is questioned by your Committee.

Consideration was given by the Labour Relations Committee of the Canadian Nurses Association to the possibility of joining with the professional groups, which asked for separate bargaining legislation for professional workers. This raised the question of the status of nurses. Is nursing a profession in the legal sense? This question was also referred to the Provincial Associations who again sought legal advice.

Nova Scotia was advised that members of the Registered Nurses Association enjoy the privileges and status of a profession, because they are so named in the Registered Nurses Association Act of 1931. New Brunswick reports that the Director of Labour states that the only phase of nursing that might possibly come under labour legislation is the Industrial Nurse. The controllers of industrial plants state that the nurse is a confidential employee and has the same status as a lawyer or minister. The status of the industrial nurse is now being argued upon by the New Brunswick Department of Labour. Manitoba's legal adviser states that in accordance with all legal interpretations of the definition of a profession in Canada and the United States, nursing is now a profession. Alberta reports that the Registered Nurses Act of 1941 falls short of establishing nursing as a profession inasmuch as it does not legally constitute membership in the Association, a condition precedent to the practice of

nursing. Saskatchewan reports that, on the advice of their legal adviser, it is not considered advisable at the present time to seek further interpretation of the status of nursing in that province.

Due to the conflicting interpretations of the status of nursing as a profession and with the advice of our legal adviser, the Canadian Nurses Association did not join with the other professional groups in their efforts to secure a separate code governing collective bargaining for professional workers. The Committee, therefore, felt that if it is not legally possible for their Provincial Associations, in the majority of Provinces, to act as bargaining agents for nurses, that a modified resolution should be considered by the Executive Committee to replace the resolution of November, 1943, and that some other method of collective bargaining for nurses be devised by which this responsibility can be kept within the professional group.

The Labour Relations Committee invited Miss Margaret Mackintosh, Chief of the Division of Labour Legislation, Dominion Department of Labour, to meet with the Committee on May 15, 1945. Miss Mackintosh substantiated the opinion received from the five provinces that the Provincial Registered Nurses Associations could not act as bargaining agents. Arising out of information submitted by Manitoba and Alberta, the following recommendation was the result of this meeting:

That the National Committee on Labour Relations advise the Executive Committee that we suggest to the Provincial Associations that they consider the following plan:

That the local or district organization of the Provincial Registered Nurses Association select three or more *employee members*, who would inform themselves on Labour conditions in their locality and be prepared to act, if asked, as a certifiable negotiating or bargaining group, either with or without representatives from the nurse employees affected in any disagreement.

Miss Mackintosh feels that the certi-

fied bargaining group should be chosen locally for their interest in and knowledge of local conditions. Whether this negotiating group would act as members of the local or district association, or as interested individuals in their personal capacity, would depend upon the legal interpretation in each province. It would seem from the legal advice received from Alberta that they might act as members of their Association, but in Manitoba, they would act as individuals in their personal capacity.

It is further suggested that each Provincial Association have an active Labour Relations Committee, as distinct from their Legislation Committee, but have an interlocking membership, especially applied to the two conveners. That this provincial Labour Relations Committee, with the approval of the Executive Committee or Board of Management, be prepared to act with the certified negotiating group in an advisory capacity, in order to add the influence of the Provincial Association to the bargaining group.

That the National Labour Relations Committee with the approval of the National Executive Committee be prepared, if asked by the provincial Executive, to act in an advisory capacity with the provincial Labour Relations Committee and the certified negotiating group, provided the agreement contemplated is of major importance, and the added influence of the National Association would be of value.

It should be *clearly* understood that this advisory assistance would be available, only if the agreement contemplated has the approval of the Provincial Association and, if required, of the National Association.

While this type of organization seems somewhat involved, it would provide, within the professional nursing group, means through which the members of the Provincial Association could look to their own Association for assistance, in their collective bargaining agreements.

Its possible success would depend on the willingness of the dissatisfied nurses to call upon the personnel selected as the negotiators.

Trade Unions

The question as to whether professional registered nurses should become members of Trade Unions is a matter of grave concern.

The thinking of the Labour Relations Committee is, that solely for the purpose of collective bargaining, they should not. We do, however, think that we should have a tolerant and questioning attitude toward the type of organization which, in spite of all the criticism that can be brought against it, has resulted in improving the working and living conditions of millions of our fellow citizens during the last century.

The groups of nurses most likely to become involved in the question of affiliation with Trade Unions, at the present time, are nurses employed in provincial and civic departments of health and nurses in hospitals where there are employees associations. Nurses in industry may also be affected. The present practice is as divergent as the opinion in reference to the professional status of nurses. Nurses in the Department of Health in Calgary state that the only bargaining agent the City Council will recognize is "The Civic Federation of Employees", which is affiliated with a labour union. Until recently the public health nurses were not members of this group. They were dissatisfied with their salary schedule, but could get no action. At the request of the sanitary inspectors, the public health nurses, dentists and clerical workers of the Health Department decided to form a separate Local. One hundred percent of the nursing staff are in favour of joining. Dr. Hill, the M.O.H., and the heads of the Civic Federation approve. This Health Department Local is affiliated with the Civic Federation of Employees and with the Trades and Labour Council.

In Toronto, the nurses of the De-

partment of Public Health are considering joining (if they have not already joined) the Toronto Municipal Employees Association, Local 79, of the A. F. of L. affiliated with the Trades and Labour Congress. The nurses are stressing "What nurses can contribute to union organization rather than the benefits they may derive". Three physicians of the Department and the social workers of the welfare Division are already members of the union organization. The dental staff were considering the matter at the time of writing. The nurses, and I think the social workers, have a definite agreement in writing with the Trades and Labour Congress that they would not be expected to strike. The Trades and Labour Congress stated in writing that for the last three years they have been on record as favouring a "No strike policy" for nurses and for professional workers in essential services. Insofar as the National Labour Relations Committee has information, other groups of nurses affiliated or that have been asked to affiliate with Trade Unions are nurses employed as civil servants by the Provincial Government of Saskatchewan, and nurses of the Department of Health, Montreal, Saskatoon, Regina and Moose Jaw. Our information states that some nurses have already joined, but is not clear as to the position of the groups as a whole. Nurses on the staff of the Civic Hospital in Saint John, New Brunswick, through their Employees Association, are affiliated with the Trades and Labour Congress of Canada.

While we know that some industrial nurses have joined the union, favoured by the plant in which they work, we have not the information on record. The information we have shows the trend toward Trade Union participation by nurses. For public health nurses and social workers, the effect of whose service is so dependent on the financial ability of families to maintain a decent standard of living, this trend is quite understandable.

These experiments in Union Association have value for Canadian nurses as a whole. We can only learn from experience, but we must move slowly.

Other Dominion and Provincial Labour Legislation that Affects or may Affect Nurses:

Unemployment Insurance

The Alberta Labour Relations Committee has asked for information as to whether all graduate registered nurses, regardless of position, come under "The Unemployment Insurance Act of 1940". Nursing under this Act is an excepted employment. The Act states, under excepted employment:

Employment in a hospital or in a charitable institution where in the opinion of the Commission such hospital or charitable institution is not carried on for the purpose of gain.

Employment as a professional nurse for the sick or as a probationer undergoing training for employment as such nurse.

Employment at a rate of remuneration exceeding in value two thousand dollars a year is also excepted.

Whether or not nurses may wish to come under unemployment insurance is a matter for consideration.

Minimum Wage Legislation

While in most provinces this type of legislation does not affect professional nurses, it should be watched carefully by each province.

Wage Control Orders

At the time of submitting the report of this committee at the biennial meeting in Winnipeg, it was not thought that this type of legislation could affect nurses. It is now reported that in February, 1945, the salaries of nurses in doctors' offices in Lethbridge, Alberta, were by order of the War Labour Board reduced from \$115 to \$100 a month for senior nurses and set at \$80 per month for new employees. The salary of an untrained receptionist was set at \$90. While this is a provincial matter, your committee has asked Miss Mackintosh to give us advice on this ruling.

Workmen's Compensation Act

There is considerable divergence in the practice of hospitals and organizations as to whether nurse employees are included under these Acts. As this again is provincial legislation, it should be considered by the provincial Labour Relations Committees.

With the end of the war in Europe, and possible changes in both Dominion

and Provincial Government administration, there will no doubt be changes in Labour Legislation. We must keep ourselves informed of such changes as they affect the nursing profession.

ESTHER M. BEITH

Convener, Labour Relations Committee Canadian Nurses Association

Through the Years

E. FRANCES UPTON

In December last, when plans were launched for the celebration of our twenty-fifth anniversary, I was asked to prepare a brief history of those years. I accepted the honour very reluctantly, feeling in my bones, that, apart from the fact that I possess no particular ability to write things, to complete this assignment on time was a physical impossibility. However the story has been written. I might call it "an experiment in mutual understanding". I choose that title because I have always believed that that is exactly what our Association stands for and, having been closely associated with its work and development for sixty-four percent of its lifetime I am beginning to believe that the experiment could work if the one and only thing which retards its progress were removed. That weakness is, and I say this with sincere apology to the Hon. Winston Churchill, "So much is expected by so many of so few".

Towards the énd of the first world war, when events similar to those which we have experienced since September, 1939, persuaded nurses to pool their resources and work for a common cause and aim, a small group of leaders in nursing in Montreal brought into being The Graduate Nurses Association of

the Province of Quebec which had for its main objective "The improvement of the lot of the smaller school", the securing of legislation to establish standards in preparation for nursing services being, of course, the idea in the back of their minds. For three years this little group laid the foundation for the society whose twenty-fifth anniversary we have been celebrating and to whom much of the success attained is due.

Their first meeting was held on July 9, 1917, in Montreal when Miss Grace M. Fairley was appointed president and Miss Mabel F. Hersey, honourary secretary. Miss Fairley continued in office for two years resigning when she left Montreal. Miss Hersey carried on and formed the bulwark around which the whole structure developed.

During their first annual meeting held on September 16, 1918, reports indicated that "a proposed bill to provide for the legislation of nurses had been drawn up and fully discussed, amendments made and the final draft forwarded to the Association's legal adviser, a copy having been sent to the Montreal Medico-Chirurgical Society for approval, criticism and support". Miss Jean Gunn, president of the "Canadian National Association of

Trained Nurses", later known as the Canadian Nurses Association, was guest speaker, her address being "The Value of Centralization of Teaching".

Fifteen English-speaking nurses, whose names are listed in the minutes, six from Hôtel-Dieu and three sisters from Hôpital Notre Dame constituted the audience upon that historical occasion.

The Committee was re-elected and plans were laid to approach the V.O.N. regarding "the possibility of recognized training schools sending their pupils for a two-months course in V.O.N. work in order that our pupil nurses might learn how to teach hygienic living". That was in September, 1918.

Space will not permit me to enumerate the steps taken and the opposition encountered. Suffice it to say that this indomitable and courageous group reached its objective and on February 14, 1920, the Lieutenant Governor of the province signed their bill which provided the State's recognition of graduates in nursing in this province, and created the Association of those so qualified. It is a significant fact that growth cannot take place in any institution without an organization in which the people concerned can come to some agreement as to their goals or objectives. Until we have unity of purpose among individuals, growth in terms of improvement cannot be achieved. These leaders of ours, conscious that the advancement of nursing could only be accomplished by greater unity of purpose and understanding and, in a sincere endeavour to improve existting conditions, secured the one instrument which provided the first step in that endeavour, namely Registration.

The objectives of our Association since that day in 1920 have been three-fold and all inclusive. They are:

To provide a body of fully qualified and competent nurses for the care of the sick, to provide means whereby those who possess such competency and training may be made known to the public and also to promote the efficiency, usefulness and welfare of nurses generally.

That has been for twenty-five years and still is, "our task" — 'tis a heavy one and requires the individual effort of each one of us.

Provided with the tools, and armed with a goodly supply of human wisdom and understanding, the great work began and continued on a voluntary basis for the first five years. Only another group of women might match that for courage and determination. How many of you know that during the first year Miss Hersey and Mlle Guillemette acted as Registrar, in addition to their fulltime jobs, during which time they registered 1,415 nurses. As soon as R. N. certificates made their appearance, opposition began to develop and in 1922, in order to avert disaster, a compromise was made through Act amendment. We will not dwell upon the effects of this first rebuff because such difficulties have long since been removed.

The early development of the organization was greatly aided by the facilities and opportunities afforded through the schools for graduate nurses established at McGill and the University of Montreal. Refresher courses were conducted under Association auspices and scholarships were provided for members wishing to avail themselves of these new and excellent opportunities.

With the formation of sections, of service groups and special committees, our relationship with our confreres in the other Canadian provinces, the United States and the world at large was firmly established and has developed and prospered to the extent of our contributions to the common cause.

In keeping with the progress of the times our standards were raised in 1925,

(Concluded on page 646)

Nursing Education

Contributed by

COMMITTEE ON NURSING EDUCATION OF THE CANADIAN NURSES ASS'N.

The Past and the Future

The war is not over, and there is still much emergency nursing to be done; but the end is in sight, and our planning now must be for the future. At this transitional point, we naturally pause for a moment to ask ourselves what has been done in Canadian nursing during six years of war, and what suggestions this experience holds for the future. What permanent benefits might accrue from the experience? What lessons can be learned for nursing education? What are the matters that have emerged to claim the attention of the Canadian Nurses Association and the Committee on Nursing Education, and what will be their place in the future of Canadian nursing?

One of the great landmarks was the Government Grant — the grant by the Federal Government to the Canadian Nurses Association, to be used for educational purposes, with the primary objective of producing more well qualified nurses. This naturally suggests the possibility of grants from the provincial governments. It raises also for the careful consideration of all nurses the whole question of responsibility for and control of nursing education. On the one hand we are told that nursing education, like all other education, is the responsibility of the state; on the other, we are warned to beware of bureaucratic control. Does the one necessarily imply the other? These are not simple questions, but it will be observed that in this country the Government Grant was made outright to the professional association and, within the broadly stated purposes for which

it was made, was controlled and disbursed entirely by the Association.

Another question which arose early in the war was that of accelerating the basic educational program. The Education Committee was asked to prepare a plan for this, and outlined a course by which students would be available for service in two and a half years. As far as we know, this plan has been used by one school only. Much nursing opinion has felt strongly that while there were far more applications for the armed services than were accepted, and while large numbers of nurses continued on private duty registries and refused, and were not officially required, to do general duty in hospitals, telescoping of the basic training to meet service ends was quite unjustified. This may be true. On the other hand, it does not dipose of the fundamental problem of whether the traditional three years is, in fact, the optimum period for basic training in bedside nursing.

A large number of nursing auxiliaries, voluntary and paid, military and civilian, have received varying degrees of training and have participated in nursing during the war. Where does this lead? Will many wish to continue in nursing? Is there a need for their services? What of their further training, conditions of work, the control of their practice?

Many returning members of the women's services are interested in professional nursing and are eligible for nursing schools. Among the questions raised in this connection is that of how such a prospective student will select a nursing school. The Executive Committee of the Canadian Nurses Association has referred the matter of the accreditation of nursing schools to the Committee on Nursing Education for study and recommendation.

Finally, there still remain on the agenda the questions of a Canadian Nur-

ses Association First Aid qualification for nurses, and of the second type of professional nurse.

These, then, are the problems which will occupy the immediate attention of the Committee on Nursing Education, and on which all Canadian nurses should be thinking with them.

Through the Years

(Concluded from page 644)

by Act amendments, which more fully described an approved school of nursing and set examinations as a requirement for registration. The work carried out by our Boards of Examiners from that time merits the highest possible praise and appreciation.

Delegates of both language groups have represented us at all conventions of our national association held through the years and have carried our voice across the seas in 1933 and 1937, when they shared the experience of the congresses of the International Council of Nurses. We have been privileged to have been hostess group to the Canadian Nurses Association upon two occasions and will never forget the thrills we experienced when we helped to steer the sixth Quadriennial Congress of the International Council of Nurses held in Montreal in July, 1929. Registration at that time indicated the largest convention ever held here. Yes! Verily! we shall never forget that experience.

When our country declared war in September, 1939, we immediately took stock of our resources and found the names of one thousand of our members on the voluntary enrolment for national emergency — that thousand and many more were available immediately. The preparation of instructors in First Aid was organized at once, to be followed by lectures and demonstrations in air raid precautions and the results of gas attack. Thousands of our members have

shared this valuable knowledge and the modern teaching of First Aid has been included in our school curriculum. Now that victory in Europe has been won, our special committees, appointed for the purpose of assisting in post-war planning and the rehabilitation of service personnel, are ready and alert to guide our endeavours, in relation to our responsibility towards other groups with similar aims and interests.

Where are we? What are we doing today? Fourteen thousand, five hundred and eleven have been received into membership during the years under review, 5,058 on training alone, 8,483 on training plus special examination and 970 by reciprocity. Our requests for reciprocity have involved a study of the nursing laws in all the Canadian provinces, most of the States in the U.S.A., Australia, England, Scotland, Norway, Denmark, France, Finland, Holland and Sweden.

In conclusion may I suggest that we remember and honour that little band of pilgrims who, having contributed to the organization and development of our Association, are now numbered among the "Saints who from their labours rest". To the grateful memory of Mary Shaw Barrow, Louise Bérubé, Huberta Chagnon, Mabel Clint, Louisa Dickson, Sister Fafard, Mabel Hersey, Mother Mailloux, Lillian Phillips, Mary Samuel, Ethel Sharpe, Flora Madeline Shaw, Nora Tedford, Zaidee Young, Christina Watling.

STUDENT NURSES PAGE

Advice of One Student to Another

BRIDGET MULLIGAN

Student Nurse

School of Nursing, Misericordia Hospital, Edmonton.

Dear Elizabeth:

So you are discouraged! Being a student myself, and moreover your best friend, you will permit me, won't you, to give you a helping hand? I know what you are going through. I understand your feelings for they were mine one day.

It was only four months ago that you bade your family and friends good-bye, and boarded the train to begin your new career. When you first arrived in the city do you remember how it fascinated and excited you? The first week in the residence was just what you had expected - every one was so helpful and considerate. However it does not take long, unfortunately, for "cliques" to form. Clothes, personalities, hobbies and manners make fissures too great for the average young person to span. You kept wishfully thinking that you would become adjusted in time without any conscious effort on your part, and all the while the entire situation was undermining your self-confidence.

The first day you went on the floors you just knew you couldn't do as well as Mary, because she had wit and personality. Everyone said so. Betty's hair and clothes were always in such perfect order. Doreen could sing like a bird and play the piano too. Seriously now, Elizabeth, can you tell me what real

difference wit and musical talent makes to people when they need nursing care? As for clothes, we are all offered the same chances to look neat and trim in our uniforms.

These were the things that really mattered to you that first morning. It would not have been surprising had you spilled a tray, dropped a wash basin, or knocked over a screen. Head nurses and seniors can loom as insurmountable hurdles to a mere preliminary student and that is just what they were to you. Gradually you began to feel that you were being singled out as a target for their wrath. Each day added more depth to the already overwhelming whirlpool of discouragement that was steadily engulfing you. Finally you gave up even trying to study for examinations; doubt and fear of failure had set in. You had no one to turn to for that extra pat of encouragement that means so much. So you groped about, not realizing that the required strength must come from within.

You need not be discouraged, nor need you fear failure, for success is primarily a state of the mind. If one feels one is a success that is the first step toward the goal. You say you like nursing more than anything else, and yet you are willing to hand in your books and uniforms and quit! That sounds a

AUGUST, 1945

bit unreasonable to me, wanting something so badly but walking out on it because you think you are a failure. It leaves you with a feeling of disappointment, mostly with yourself, doesn't it? In some cases confidence in oneself might be "false pride", but not so in your case. Anyone who has passed the rigid entrance qualifications which a student nurse must, should never allow the word failure to cast a shadow over her training days. The diploma which entitled you to enter the school of nursing, should also give you the inspiration and confidence you need in your theory. Next to confidence as a requisite to success comes determination. Few people realize how essential just a bit of "oldfashioned spunk" is. It is that quality which forces us to keep practising even if our first attempt at bandaging was bad. It is that inner voice that urges us on - tomorrow will be better. Determination is not a native quality; it is a long and steady process, a day-by-day building. So you see you are offered the same chance for success as your classmates, bearing in mind that you must have confidence and determination. Take stock of your outward appearance. Choose your ideal type of a nurse and never let her image fade from mind.

Another requisite for success is the thirst for knowledge. It is an inner urge and must not only be present through the three years of training, but all through one's life. It must make a nurse desire a thorough understanding of her own daily work, and also of the new and many vast fields in science and medicine that are opening up to her. A nurse must remember that she is a pillar of strength to those around her. She is the only contact with the outside world that some of her patients have. Therefore she cannot for a fleeting second let her confidence fail her, lest her patients feel that she is at loss for a solution to their problems. A patient will never quite trust a nurse again who has betrayed this confidence.

Being a good nurse is the same as being a renowned musician or a famous athlete. These people do not learn their skill in a day. They practise daily, and so must the nurse. Each day brings something new and interesting. However, understanding must come first — for without knowledge of what one is attempting to do, practise would prove useless.

From all this, Elizabeth, you will gather that I am not urging you to stick with nursing as a three-year course; I feel it is a life work. In any career one must accept the dark days with the bright ones; similarly, in nursing. The nurse not only serves humanity, which in its pettiness may remember or forget her, but she is constantly serving God, who never forgets even the smallest of her hardships. To me nurses have a distinct advantage over people of other professions. There is such a wealth of satisfaction to be derived from the smallest task in nursing. Just a simple "thank you" from some aged woman to whom she has given a drink, or just the smile of gratitude in the eyes of some suffering young patient can make a nurse's spirits soar to heights unknown to the average work-a-day world. In a nurse's life there is such a close association of sorrow and happiness, of life and death, that some religious life is necessary. It is this gentle tone which helps to blend all other qualities of a nurse into an admirable character.

So, Elizabeth, square your shoulders just a little bit more, as you pin on your bib and apron tomorrow morning. Tilt your chin just a little higher as you put on your cap, and smile just a little oftener as you begin on your renewed attempt at being a successful nurse. You can do it.

Sincerely yours,

EVELYN.

Manitoba Student Nurses' Association

Despite the many "growing pains" of our new Association, it is felt that all members have derived benefit from our meetings. They have broadened our outlook on nursing and have made us realize that nurses everywhere have common problems. Each of us has enlarged her circle of friendships. The Association has broadened the outlook on student life for many of us. We have actually seen many fine things that other training schools are doing, and this makes

us aspire to better things — for example — the St. Boniface Hospital Student Dramatic Club and the Winnipeg General Hospital Record Night.

It has brought us all in closer touch with the M.A.R.N., what it can do for us, what we can do for it. We will be better M.A.R.N. members for having been members of our M.S.N.A.

DOROTHY MARSHALL
Past President, M.S.N.A.

Valuable Chemical Harvested from Lake

Crystal-covered lakes dotted across the Canadian prairies yield each year an unusual and valuable harvest of a widely used chemical compound, sodium sulphate.

When investigation of the deposits in White Shore Lake, near Palo, Saskatchewan, was first undertaken by Canada's Department of Mines, it was estimated that approximately 19,760,000 tons of hydrous salts existed in the lake in deposits varying in depth from three to seven or more feet.

Tens of thousands of tons of the dehv-

drated crystal, known to the trade as "salt cake", are required each year in the manufacture of kraft paper. Canada's glass industry also uses the chemical and large tonnages are required in the smelting of nickel and copper ores and in various branches of the chemical industry.

In the late summer and in dry seasons, the lake becomes a huge deposit of crystallized salts. These deposits are harvested by scrapers and fleets of trucks which pile up huge reserve stocks.

Victorian Order of Nurses for Canada

The following are the staff appointments to, transfers, and resignations from the Victorian Order of Nurses for Canada:

Mary Bastedo and Winnifred Tredaway, who have been on leave of absence with scholarships from the V.O.N., having completed their course in public health nursing, have been posted to the staffs in Brantford and North York (Ontario) respectively. Marguerite Ries, having completed her course in public health nursing at the University of B. C., has been appointed to the Gananoque staff.

Margaret Baker (Vancouver General Hospital and public health nursing course, University of B.C.) has been appointed to the Burnaby staff. Isabel Barron (St. Joseph's Hospital, Winnipeg, and public health nursing course, University of Toronto) has been appointed to the Winnipeg staff. Beryl

Crawford (St. Joseph's Hospital, London, and public health nursing course, University of Western Ontario) has been appointed to the Waterloo staff.

The following nurses have been appointed to the Toronto staff: Bernice Bannister and Frances Y. Carroll (Brantford General Hospital) and Marion A. Hatcher (Royal Victoria Hospital, Montreal). All have taken the public health nursing course at the University of Toronto. Dorothy Wyeth (Victoria Hospital, London; B.Sc.N., University of Western Ontario) has been appointed to the Border Cities staff.

Louise Steele has resigned as nurse-incharge of the London Branch to accept a position with the Ontario Provincial Department of Health. Ellen Holland has resigned from the York Township staff to be married.

AUGUST, 1945

M.L.I.C. Nursing Service

Monette Gervais (St. Françoise d'Assise Hospital, Quebec City) has completed the public health nursing course at the University of Montreal and will return shortly to the Mount Royal Nursing Staff.

Jeannine Coupal (Ottawa General Hospi-

tal and public health nursing course, McGill School for Graduate Nurses) recently resigned from the Company's service. Before joining the R.C.A.F. in January, 1942, Miss Coupal was nurse-in-charge at Chicoutimi, P.O.

Ontario Public Health Nursing Service

Irene Weirs (Wellesley Hospital, Toronto, and University of Toronto public health nursing course), who has been until recently the public health nursing supervisor at Fort William, has accepted the appointment as supervisor of the Welland-Crowland Unit.

The following graduates of the public health nursing course at the University of Toronto have accepted appointments: Mildred Laughlen (Belleville General Hospital) with the North Bay Board of Heath; Elizabeth Pike (Toronto General Hospital) with the Welland-Crowland Health Unit; Margaret MacMackon (Royal Victoria Hospital)

tal, Barrie) with the Kirkland-Larder Lake Health Unit; Ethel Rutledge (Kingston General Hospital) with the Guelph Health Department; Barbara Wood (Kingston General Hospital) with the Hamilton Department of Health.

The following graduates of the University of Western Ontario public health nursing course have accepted appointments: Irene McCarty (Ontario Hospital, London) with the Welland-Crowland Health Unit; Elizabeth Skinner (Stratford General Hospital), with the Port Arthur Department of Health; Georgina Harrington (Ontario Hospital, London) with the Middlesex County School Health Unit.

Saskatchewan Public Health Nursing Service

Doris Corcoran (Holy Cross Hospital, Calgary) and Genevieve Matheson (General Hospital, Port Arthur), who have recently joined the staff, have taken up their duties in the Assiniboia West and Shaunavon South districts respectively.

Sara Bayard and Roberta Cornelius (Regina General Hospital), who joined the staff at the beginning of the year, are working in the Regina and Kerrobert districts.

Louise Miner, the most recent appointment to the staff, completed the University of Toronto public health course in May.

Marion Douglas of the Kindersley district has resigned to be married.

Marjorie Leger, Edna Moore and Blanche Treble, who have recently returned from University, have gone to the districts of Wynyard, Preeceville and Maple Creek, respectively.

Evelyn Boyko transferred recently to the Tisdale District.

Mrs. H. A. Fletcher, who has been working in the Tisdale district, transferred to the Estevan Larger School Unit. In addition to a generalized program of public health nursing, Mrs. Fletcher will carry on a special health education program in the schools of the unit.

Lorena McColl, North Battleford, took part in the program of the annual S.R.N.A. convention, speaking on the subject, "How The Canadian Nurse has helped the public health nurse".

What is Acid-Moisture ?



Dermatitis in infants brought about by wet diapers, clothes and bed clothes is a common and troublesome condition. Because of it the busy physician is often faced with questions from anxious mothers. While normally acid because of uric acid content (C₆H₄N₄O₃), urine is sometimes converted into an alkaline irritant in the "ammoniacal diaper" by urea-formed ammonia (NH₃).

On the basis of simple mechanical protection, the use of Z.B.T. Baby Powder

with olive oil helps to resist moisture dermatitis. Z.B.T. clings and covers like a protective film—lessens friction and chafing of wet diapers and shirts. The mechanical moisture-resisting property of Z.B.T. may be clearly demonstrated. Smooth Z.B.T. on the back of your hand. Sprinkle with water or other liquid of higher or lower pH. Notice how Z.B.T. Baby Powder keeps skin dry as the drops roll off. Compare with any other baby powder.

Z. B.T.—the only baby powder made with olive oil

R.C.A.F. Nursing Service

The Director of Medical Services (Air) announces the following promotions and changes which have recently taken place in the R.C.A.F. Nursing Service:

A/Matron A. H. Nelles (Hospital for Sick Children, Toronto), has recently received her promotion and is on duty at the R.C.A.F. Hospital, St. Thomas.

N/S D. C. (Pitkethly) Lindsay (Ottawa

Civic Hospital) was awarded the A.R.R.C. in the King's Birthday List. She was with the Mobile Field Unit Overseas and was one of the first nursing sisters, to land on the continent following D-Day.

N/S N. M. (Chittim) Trotter (General Hospital, Chatham) was awarded the A.R. R.C. in the King's Birthday List for valuable service. N/S Trotter is at present on duty at R.C.A.F. Headquarters, Ottawa.

Royal Canadian Naval Nursing Service

The following nurses received honours in the King's Birthday Honours List:

R.R.C.: P/M A. R. Fellowes (Royal Victoria Hospital, Montreal); P/M F. M. Roach

(St. Michael's Hospital, Toronto).

A.R.R.C.: Matron C. A. Evans (Victoria Hospital, London): N/S M. I. Green

(Toronto General Hospital).

NEWS NOTES

ALBERTA

supervision, specializing in surgical nursing.

EDMONTON:

Royal Alexandra Hospital:

Three graduates of the Royal Alexandra Hospital School of Nursing have recently been awarded scholarships and will take university post-graduate courses this autumn. The R.A.H. Alumnae scholarship was awarded to Jean E. Mackie, Class of 1944. She purposes taking a course in clinical supervision. One Tegler scholarship goes to Olive Keith, assistant supervisor of the children's ward, who will take the course in clinical supervision with pediatrics the specialty chosen. The other Tegler scholarship has been awarded to Florence Watkins, charge nurse on the men's surgical ward. She will also take the course in clinical

BRITISH COLUMBIA

KAMLOOPS:

The annual meeting of the Kamloops-Okanagan District, R.N.A.B.C., was held recently with about forty members for dinner, among whom were delegates representing the six chapters — Salmon Arm, Vernon, Penticton, Kelowna, Princeton and Kamloops-Tranquille. At the conclusion of dinner the members were delightfully entertained with musical numbers supplied by local talent. Following this the business meeting was conducted by the president, O. Garrood. The delegates read interesting reports of their year's activities, showing that much had been accomplished.

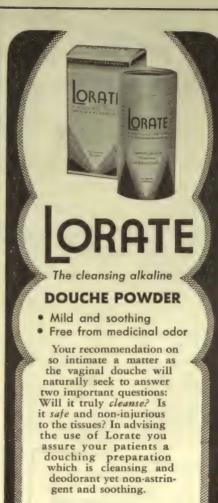
Helen MacKay, of the Royal Inland Hos-



Compare your complexion with your shoulders. You'll find your shoulders look 5 or more years younger. Why? Because shoulder pores are kept clean by your regular Palmolive Soap baths—and so, able to breathe freely. But face pores, clogged with dirt and make-up, can't breathe freely and soon your complexion loses its flexible softness and ages before its time. That needn't happen to your complexion. Palmolive offers an easy way to keep it radiantly lovely.

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Wash your face 3 times a day with a face-cloth massage Palmolive lather into your skin—for an extra 60 seconds! This easy Palmolive Massage stimulates the circulation, clears the pores to help your complexion regain its flexible softness, becomesofter, smoother in just 14 days!

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3. Rinse the underarms well with clear water or wipe off with a damp



4. If these directions are followed, you and your garments will be doubly



days' protection. 3 SIZES: 39c. 15c., 65c.

"Regular"—1 to 3

pital, was asked to take the chair for the election of officers for the coming year. Miss Garrood was unanimously returned to office for a second year of able presidency. Mrs. M. Pegeau of Penticton was elected vice-president and Mrs. W. Waugh, Kamloops, secretary-treasurer. The conveners of the various committees were elected as follows: Mrs. Mary Barton, hospital and school of nursing; Miss Newby, of Kelowna, public health; I. Harbell, of Salmon Arm, general duty and private nursing. Miss Garrood was voted councillor to the provincial executive, and Helen Mac-Kay as delegate to attend the provincial annual meeting. The new vice-president then extended a hearty invitation to hold the district meeting next October at Penticton.

The speaker of the evening was Dr. F. A. Humphreys, bacteriologist of the Laboratory of Hygiene, Department of National Health and Welfare, who spoke on "Tick and Insect Borne Diseases". Slides were shown depicting closeups of tick and insect life which proved both interesting and instructive. Mrs. Barton thanked the speaker. Several of the student nurses from the Royal Inland Hospital arrived in time to enjoy Dr. Humphreys' lecture.

During the afternoon the visiting delegates and executive of the Chapter were entertained

at the home of Mrs. Roy Bell.

The Valentine tea held in February was a great success, \$272.25 being realized from the apron stall, white elephant table, tea and raffle.

CHILLIWACK:

Miss D. Priestley, retiring president of the Chilliwack Chapter, R.N.A.B.C., dealt briefly with the four years work done by the organization here at the recent annual meeting. An interesting note was the fact that Miss Claire Tait, first president of the Chapter, has accepted a position with UNRRA and will serve in Europe. Miss Priestley extended thanks to matrons of Chilliwack Hospital, Chilliwack Military Hospital and Coqualeetza Indian Hospital tor acting hostesses, and to officers and members for loyal support.

New officers include: A. McKay, president : M s. E. B. M. Kennedy, vice-president; E. Morton, secretary; F. Roberts, treasurer; chairmen of sections: K. Crowley, hospital and school of nursing; D. Priestley, public health; Mrs. C. S. Pennock, general nursing. Standing committees include: p.ogram, Mmes. H. R. Hatfield, H. K. Arnould; refreshments, F. Roberts, J. Hall E. Sloane; membership, T. Fagan, M. F. Bridges, Mrs. Carl Webb; The Canadian Nurse, L. Hodgkins; press and publications, Mrs. J. D. Munroe; visiting, Mrs. Storey; ways and means, Mrs. T. E. Heaton.

A committee was appointed to handle

Special Nurses Emergency funds. Two gift subscriptions to The Canadian Nurse will be sent to Chilliwack girls graduating this

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NEW GLASGOW:

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THE HAKE

The unveiling of a plaque honouring graduates from Aberdeen Hospital School of Nurses who had entered the fighting services took place recently in the presence of more than fifty persons.

The plaque was donated by the Aberdeen Hospital Alumnae Association and was unveiled by Mrs. Eaton, the oldest graduate. Mrs. Harry Murray, president of the Alumnae Association, spoke briefly, and Canon I. E. Fraser noted the service of Florence Nightingale in war and how her example had been followed. Dr. W. H. Robbins told of the services he had seen nurses perform in the last war.

The plaque has been placed on the wall of the waiting room by the main entrance of the hospital. Tea was served by Alumnae members at the conclusion of the ceremonies.

Following are the names of the graduates of Aberdeen Hospital who are now in the services: Frances Charman, Nellie Mills, Ethel Duncan, Ruth Milligan, Helen Morash, Isabel Thompson, Mae MacChesney, Evelyn Negus, Mabel MacKenzie, Ruth Fawcett,

Sarah Miller, Jean Johnson, Beryl Ripley and Margaret Treen.

The Alumnae Association recently held a rummage sale which netted \$90. The proceeds will go towards the endowment of a room in the new hospital which is under consideration.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications. Miss Gena Bamforth, 54 The Oaks, Bain Ave., Toronto

DISTRICTS 2 AND 3

Brantford General Hospital:

The graduation exercises of the Brantford General Hospital School of Nursing took place recently when The Most Rev. C. A. Seager, D.D., Archbishop of Huron, addressed the class. In the afternoon a garden party was held at the hospital. In the evening a dance was much enjoyed by the nurses

BACK COPIES WANTED

To complete the set of bound volumes in the office of The Canadian Nurse the following issues of the Journal are required:

1911: Jan. to Dec. inclusive.

1912: Jan. to Dec. inclusive.

1913: Jan. and Oct.

1914: Jan., Feb. and June.

If any subscriber has these issues in their possession and would be willing to sell them, kindly communicate with the The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P. Q.

Proper Illumination

Requests for illumination studies are being made with increasing frequency. Certain factors are found common to all of the places studied and are probably typical of situations in office cubicles. These are:

- 1. An intensity of illumination from artificial sources entirely inadequate to meet the needs of the seeing job being done.
- 2. A serious degree of glare at windows resulting either from direct sunlight or sunlight reflected from light coloured buildings.
- 3. Excessive contrasts in degree of illumination as a result of desk lights used in an effort to correct for inadequate intensities of general illumination.

Replacement of incandescent lighting fixtures with fluorescent lighting fixtures provides the most desirable remedy in most cases. Modern fixtures are difficult to obtain, however, and the changes in wiring increase the cost.

-California's Health

and their friends. A week later the Alumnae Association entertained the graduates at

a banquet and dance.

The Association held their closing meeting for the season on the terrace of the hospital grounds, where an enjoyable picnic lunch was served. Miss Helen Cuff, the president, conducted the meeting and the election of officers took place as follows: Honourary president, J. M. Wilson; president, H. Cuff; vice-president, O. Plumstead; secretary, M. Patterson; treasurer, Mrs. J. Oliver; committees: gift, J. Landrette, V. Buckwell; flower, M. Malloy, L. Burtch; social, Mmes J. Grierson, P. Smith; representatives to: Local Council of Women, Mrs. E. Walton; Red Cross, Mrs. A. D. Riddell; The Canadian Nurse and press, D. Franklin.

DISTRICT 4

HAMILTON:

A regular meeting of the Hamilton Chapter, District 4, R.N.A.O., was held recently at St. Joseph's Hospital, with Miss Blackwood presiding. Miss Jean Masten, president of the R.N.A.O. and superintendent of nurses, Hospital for Sick Children, Toronto, presented to the meeting some of the more recent trends in nursing such as "The Practice Act", which would give legal status to nurses, the advisability of setting up a placement bureau for the Province, and the possibility of a pension fund for nurses. Miss Masten also spoke of the great need existing among the European nurses for uniforms, shoes, etc. To help meet this need all Canadian nurses will be given an opportunity to make a contribution.

WELLAND:

The last regular meeting of the Welland Graduate Nurses Association took the form of a business meeting with Mrs. C. Hill in charge. The room committee reported the purchase of a new mattress and was asked to have the room linen brought up to the standard amount. The final financial reports were read and a satisfactory bank balance was revealed. Fall activities were also discussed and a social hour followed.

At the annual dinner some sixty nurses were present from the various branches of nursing in the city. Mrs. Peggy Sharp and Mrs. Marg Beatty won door prizes donated by Miss Rossi. Many enjoyed a walk on the terrace after dinner and card games were

played.

DISTRICT 7

BROCKVILLE:

Miss Kay Kerr, secretary of the Brockville Chapter, District 7, R.N.A.O., reports

that a recent meeting was held in the Ontario Hospital, with Miss Preston, the new-Gilpin introduced the guest speaker, Dr. Barrie, who spoke on "Electro Shock Therapy". To stimulate interest it was decided to have an advertisement inserted in the local paper twice during the week preceding the meeting night and to include the name of the speaker. Mrs. Orr and her staff later served refreshments.

KINGSTON:

The Hotel Dieu Hospital will celebrate its one hundredth anniversary on September 11 of this year. It is the sincere wish of the Rev. Mother Superior that all graduates of the Training School will make a special effort to be present and to celebrate with the Sisters this memorable event. Invitations

the Sisters this memorable event. Invitations will be sent to each graduate in the near future and the Alumnae would appreciate names and addresses for its mailing list.

Among the Hotel Dieu graduates at the new Veterans Hospital on Princess St. are Rita Davis, Marjorie O'Toole, Esterine Johnston, Rita Cassidy, Margaret Stephens, Mildred Kennedy, Marjorie McGrath, Margaret Coderre, Eulia Wilkinson, Marcella O'Meara, Willena Hurley.

OUEBEC

MONTREAL:

Children's Memorial Hospital:

At a recent meeting of the Staff Association, as part of the education program, Dr. M. Digby Leigh, chief anesthetist, gave an interesting and informative talk on "Oxygen Therapy", complete with a film presentation and practical demonstration. The teaching department, together with the staff nurses, have been busy revising the student nurses' report forms. The present issue under discussion is the question of improving charting methods.

The following nurses have successfully completed their six-month post-graduate course; Norah Edgar (St. Boniface Hospital, Man.); Christena Geddes (Misericordia Hospital, Edmotnon); Ruby Dewar (Dauphin General Hospital, Man.)

The new class of post-graduates started May 15. They are Brenda Corker (Royal Columbian Hospital, New Westminsteri; Yacko Nagai (Vancouver General Hospital); Marie Linkletter (St. Joseph's Hospital, P.E.I.); Pauline Wright (Royal Jubilee Hospital, Victoria).

Recent appointments to the staff are Christena Geddes, Doris Lloyd and Pauline Markham (Hotel-Dieu, Windsor). Joan

McPhail has resigned.



Keep them healthy—let Baby's Own Tablets help you. Pleasant, simple tablet triturates, they can be safely depended upon for relief of constipation, upset stomach, teething fevers and other minor ailments of baby-hood. Warranted free of narcotics and opiates. A standby of nurses and mothers for over 40 years.

BABY'S OWN Tablets



SOCIAL ASPECTS OF **TUBERCULOSIS**

By S. Roodhouse Gloyne. Public health and other nurses will find this new Bri-tish book of special interest. It is an en-largement of lectures given at the Royal College of Nursing to health visitor stu-dents. It deals with infection, resistance and other problems as they concern both the individual and the community. \$2.50.

THE NURSE AND THE LAW

By Gene Harrison. "The nurse's chief concern is not only to avoid tangles with the law, but also to know enough about law to enable her to give hope and comfort to her patient if occasion arises."— L. E. Dickinson, M.D.

"There should be a place on the shelves of each nurse, beside her medical books, for this volume, in which an attempt has been made to fill a want hitherto un-satisfied." — J. H. Harrison, Attorneyat-Law. \$3.75.

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29 WELLINGTON ROW SAINT JOHN, N. B.

Royal Victoria Hospital:

Bertha Cameron and Elizabeth Stewart spent a week recently observing in neurosurgery and urology at New York Hospitals. Henrietta Adams and Jean Trenholm recently visited the Massachusetts General and the Peter Brent Brighem Hospitals. Marian McEwen, of the outdoor department staff, recently joined the R.C.N. Nursing Service.

ing Service.

N/S's Rita Ackhurst, Rita Fulton, Margaret Mowatt and Doris Carter were recent visitors at the hospital from overseas.

St. Mary's Hospital:

The annual dinner tendered by the Alumnae Association of St. Mary's Hospital School for Nurses for the graduating class was held recently with Mrs. W. E. Johnson, president of the Association, presiding. At the head table were Alyce McKenna, Regina Cowan, Patricia Corbett, president of the graduating class, Rev. Father A. Carter, Chaplain of the Association, Ena O'Hare, N/S Mary Morrow and Emily Toner.

Father Carter addressed the nurses and commended their spirit of unity and comradeship. Toasts were proposed by E. Toner, M. Barrett, G. Kennedy, E. O'Hare, and P. Corbett thanked the Association in the name of the new graduates. Arrangements for the dinner were in charge of T. DeWitt, Mrs. T. Cherry, D. Sullivan and C. Lewis. A recent visitor to town was N/S Claire

A recent visitor to town was N/S Claire Robillard on furlough from the U.S. Army Nurse Corps. Claire has been doing some interesting work in anesthesia and has seen action in China, India and Burma. Catherine Dupuis writes from Santa Barbara, Calif., that she has made application to nurse with the U. S. Navy Nurse Corps. Anne-Marie Kingston has been awarded a two-year scholarship at the University of St. Louis. Miss Kingston will take a post-graduate course in public health nursing. The degree of Bachelor of Science in Nursing has been conferred on Claire MacDonald from the University of St. Francis Xavier.

OUEBEC CITY:

Jeffery Hale's Hospital:

The graduation exercises of the Jeffery Hale's Hospital School of Nursing were held recently with a large number of relatives and friends present. Mr. J. T. Ross, assisted by Miss M. E. Lunam, presented the graduates with their diplomas and medals. Following the exercises a reception was held. A formal dance was given by the staff and Board of Governors, in honour of the Class of 1945, and the Alumnae Association also entertained the Class at dinner.

The graduating class recently held a War-

me Tea for friends in the city.

M. Taylor and M. Dickson have left to take up their duties with the Royal Canadian Navy. Mrs. Mashell has resigned as supervisor of the semi-private and pediatric wards and has been replaced by Miss Coull. Mrs. Pfeiffer has replaced Mrs. Mashell as treasurer of the Alumnae Association.
All nurses of J. H. H. who wrote the

Spring examinations for registration passed

successfully.

SASKATCHEWAN

MAPLE CREEK CHAPTER:

A dance under the auspices of the Maple Creek Chapter was held recently. Part of the proceeds have been forwarded to the British Nurses Relief Fund. The Chapter is subscribing to the Digest of Treatment and at each meeting some of the articles will be read and discussed

MOOSE JAW CHAPTER:

The first Thursday in each month five local nurses, each keenly interested in the public health field, meet for an informal luncheon. Those attending are Mmes B. Farquharson, A. Tanney, Misses K. Jamieson, N. Armstrong, La Roque.

Grace Motta, superintendent of nurses, Moose Jaw General Hospital, represented the S.R.N.A. at the recent convention of the Provincial Council of Women held in

Moose Jaw.

Kristie Jamieson recently spoke to the Central Collegiate Home Nursing class on Venereal Disease. Her lecture was met with much enthusiasm and interest by the fortytwo members present.

PRINCE ALBERT CHAPTER:

The following nurses on the Victoria Hospital staff, Prince Albert, are taking post-graduate courses at the Vancouver General Hospital: Mrs. Jean S. Harry, Mar-jorie Wilson, Gladys Anderson. Noreen Lambert, a 1945 graduate of the University of Saskatchewan School of Nursing and

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WANTED

A Matron is required immediately for the Swift Current General Hospital of 75 beds. No training school. Applicants should state full particulars as to experience, references, salary desired, and when available. Apply to:

E. H. Rice, Secretary-Manager, Box 10, Swift Current, Sask.

WANTED

An Assistant Superintendent is required for the Kootenay Lake General Hospital, Nelson, B. C. Apply, stating experience, to:

Kootenay Lake General Hospital, Nelson, B. C.

St. Paul's Hospital, Saskatoon, has accepted a position on the staff of the Holy Family Hospital, Prince Albert, as instructor. Miss Lambert graduated with distinction from the University and was presented with the award for theory at St. Paul's.

REGINA CHAPTER:

Annual Vesper Services were held in the Metropolitan Church and in the Chapel of the Grey Nuns' Hospital in May with many nurses in attendance. Mrs. E. Martin has taken up her new duties as a public health nurse. She was formerly supervisor of the children's ward, Grey Nuns' Hospital. Mrs. Dorothy Weaver has resigned her position with the Cancer Clinic, Regina, after two and a half years service.

SASKATOON CHAPTER:

Well-attended Vesper Services for nurses in Saskatoon were held in May at St. John's Cathedral and St. Mary's Church.

YORKTON CHAPTER:

In observance of Hospital Day a successful tea was recently held by the Yorkton Chapter at the Yorkton General Hospital. During the day more than one hundred guests were received.

Alice Gwilliam, of the Yorkton General Hospital operating room staff, has completed a post-graduate course in surgery at Vancouver General Hospital and has returned to the position of supervisor of the operating room.

WANTED

A qualified Instructress is required immediately for the Carman General Hospital. Apply stating qualifications, experience, and salary expected, to:

Superintendent, Carman General Hospital, Carman, Manitoba.

WANTED

Registered Nurses are required immediately for General Duty in Ex-Servicemen's Pavilion. Nurses are also required for Operating Room and Obstetrical Unit. Salaries depending upon experience. Full maintenance living out. Railway fare to Edmonton refunded after six months' service. Apply, stating experience, to:

Superintendent of Nurses, University Hospital, Edmonton, Alta.

WANTED

Nurses are required for General Duty in the Verdun Protestant Hospital, Montreal. This is a splendid opportunity to obtain psychiatric nursing experience. State in first letter experience, references, etc. and when services would be available. Apply to:

Director of Nursing, Verdun Protestant Hospital, Box 6034, Montreal, P. Q.

WANTED

A Lady Superintendent and two nurses are required for the Barrie Memorial Hospital in Ormstown. For full particulars write to:

The Medical Superintendent, Barrie Memorial Hospital, Ormstown, P.Q.

WANTED

A Nursing Superintendent and an Assistant Night Supervisor are required at once for the Cornwall General Hospital. Apply, stating experience and salary expected, to:

F. Stidwill, Secretary-Treasurer, Cornwall General Hospital, Cornwall, Ont.

WANTED

An experienced Operating Room Nurse as Office Nurse is required for a doctor in a middlesized Saskatchewan town. Duties are to begin on September 1. Beginning salary, \$150 per month. Apply to:

Dr. W. Bergmann, Meadow Lake, Sask.

WANTED

Applications are invited for the position of Superintendent of a 55-bed General Hospital with an 18-bed Maternity Annex. Apply, stating qualifications, experience, and salary expected, to:

Secretary, Board of Trustees, Colchester County Hospital Trust, Truro, N. S.

WANTED

A Registered Nurse is required for Night Duty. Salary, \$90 per month, plus full maintenance. One full night off each week. Apply to:

Scott Memorial Hospital, Seaforth, Ont.

WANTED

General Duty Nurses, registered or graduates, are required for the Lady Minto Hospital. The salary is \$90 and \$80 per month, with full maintenance. Apply, stating full particulars of qualifications, to:

Lady Minto Hospital. Cochrane, Ont.

WANTED

Applications are invited for the following positions in a 100-bed hospital with Training School:

Dietitian — required at once.

Instructor — required for September 1, 1945.

For further information apply to:

Sister Superior, Providence Hospital, Moose Jaw, Sask.

WANTED

An Operating Room Nurse is required immediately for a 200-bed Children's Hospital. Salary, \$85 per month, and maintenance. 96-hour fortnight. Apply to:

Superintendent of Nurses, Children's Memorial Hospital, Montreal 25, P. Q.

WANTED

A Superintendent of Nurses, Dietitian, and Instructress are required immediately for the Highland View Hospital. Apply, stating qualifications, to:

Secretary, Highland View Hospital, Amherst, N. S.

WANTED

An Assistant Superintendent and a Clinical Supervisor are required for a 180-bed hospital in Southern Ontario. Student body, approximately 40. Apply, stating qualifications and salary expected, to: Superintendent of Nurses, Niagara Falls General Hospital, Niagara Falls, Ont.

WANTED

General Staff Nurses are required for the Women's Missionary Hospital of the United Church of Canada at Hearst, Ont. The salary is \$100 per month, with full maintenance, less tax. Apply to:

Superintendent, St. Paul's Hospital, Hearst, Ont.

WANTED

A qualified Dietitian is required for a 117-bed General Hospital. Apply to:

Superintendent, St. Joseph's Hospital, Peterborough, Ont.

WANTED

A Senior Instructor of Nurses is required for a Training School of 60 pupils. Salary, \$135 per month. Apply, stating qualifications, age, religion, etc., to:

Superintendent, Glace Bay General Hospital, Glace Bay, N.S.

WANTED

A Registered Nurse is required as Night Supervisor; three Registered nurses are also required for General Staff Duty. Eight-hour day and six-day week, with full maintenance. Apply, stating salary expected, to:

Superintendent, Shriners' Hospitals for Crippled Children, Montreal Unit, Montreal 25, P. Q.

WANTED

General Staff Nurses are required for Psychiatric Teaching Centre. Straight eight-hour day, with one full day off duty weekly. Three weeks holiday a year; accumulative sick leave. Minimum annual salary, \$1200 less perquisites. Apply to:

Director of Nurses, Toronto Psychiatric Hospital, Toronto 5, Ont.

WANTED

An Assistant to the Superintendent of Nurses is required by the Sherbrooke Hospital. Applicants must also be able to assist with the instruction for a rapidly-expanding English School of Nursing. Position available immediately. Apply, stating qualifications, experience, and salary expected, to:

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WANTED

General Duty Nurses are urgently required for a 350-bed Tuberculosis Hospital. Forty-eight and a half hour week, with one full day off. The salary is \$100. per month, with full maintenance. Excellent living conditions. Experience unnecessary. Apply, stating age, etc., to:

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WANTED

A Superintendent is required for the Galt General Hospital of 90 beds. Applicants should have had post-graduate training in Administration and Teaching, and experience in the administration of a Training School. Apply, stating references, experience, and salary expected, to:

H. N. Simmons, Secretary, Galt Hospital Trust. City Hall, Galt Ont.

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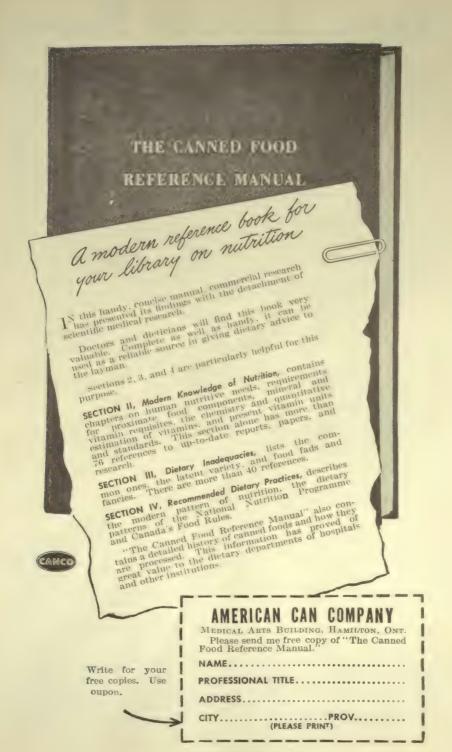
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One of the aims of Rottot's life was to teach medicine and this was realized through his membership in l'Ecole de Medicine et Chirurgie de Montreal, the first French Medical School established in Montreal. In 1878 when a Montreal branch of Laval University was formed. Rottot severed his connection with the Montreal School of Medicine and Surgery and accepted a professorship in the new Faculty or Succursale, as it was known. In this institution he taught Internal Medicine and headed the medical clinic, and when the School of Medicine and Surgery and the Succursale were united, Rottot was appointed Dean of the Faculty of Medicine.

Rottat was one of the founders and directors of Notre Dame Hospital, doctor of St. Sulpice Seminary and of the Grey Sisters. His interest in medicine was not entirely local and he was active in the Canadian Medical Association. Being of a studious nature his talents were directed into journalistic channels and he was the first director-general of the Union Medicale. Due to his wise guidance this publication survived its first few years.

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Reader's Guide

Rhoda F. MacDonald, whom we greet as guest editor this month, has been president of the Registered Nurses Association of Nova Scotia since Spring of 1944. A dynamo of energy, Miss MacDonald has all the enthusiasm of an old-time crusader as she guides the destinies of her provincial association. Born and educated in Nova Scotia, she graduated from the Glace Bay General Hospital and has served with vigour and success in various executive positions in Cape Breton Island hospitals and in Moncton, N.B. At present, she is instructress at the Sydney City Hospital. We feel confident she will find the answers to the queries she has raised.

Dr. Robert G. Langston is a young surgeon who has been accomplishing outstanding work with battle-scarred veterans. He is on the staff of the Shaughnessy Military Hospital in Vancouver. A relatively new branch of medical science, plastic surgery has developed far beyond the "face-lifting" or cosmetic surgery stage and is restoring countless injured persons to useful, normal lives. Dr. Langston's descriptions of the various techniques will be new to many of us.

The generalized program, organized under the Department of Public Health in Toronto, has long served as a model to other communities. Despite shortages of nursing personnel, the school health services, under the able supervision of Miss Gordon Lovell, function smoothly as a part of the whole. How they are woven into the general pattern makes interesting and instructive reading.

During the past few years, much ac-

tivity in all parts of Canada has had as its focal point ways and means of interesting suitable young women in adopting nursing as their chosen profession. Recently, the publicity counsel of the C.N.A., Miss Jean Mason, completed a comprehensive study of the reasons why some of these campaigns have fallen short of the mark. There is much food for future thinking and action in the reasons a cross-section of Canadian high school girls have given why they do not turn to nursing as a career.

Helen G. McArthur, who is superintendent of the Public Health Nursing Branch of the Alberta Department of Health, surveys the broad picture of public health nursing in Canada from her vantage-point as chairman of the Public Health Section, C.N.A. She is encouraged by the prospect she sees ahead and spreads the spark of enthusiasm to public health nurses everywhere in the Dominion.

Edith Weldon is a private duty nurse and a member of the Fredericton Chapter, N.B.A.R.N. Her description of the care required for her patient while in hospital has much instructive value.

Notes from National Office are well worth careful and detailed study by every nurse in Canada. They represent the summarized reports of individuals and committees which were presented to the C.N.A. executive committee at its spring meeting. No nurse can count herself well-informed on contemporary nursing activities unless she becomes thoroughly familiar with all of these reports. Their review might well serve as a chapter meeting program.

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677

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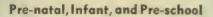
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The CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-ONE

NUMBER NINE

SEPTEMBER 1945

Nova Scotia Poses Some Questions

Recent issues of the Journal have carried accounts of the pressing need for university post-graduate courses for nurses, places where these courses may be taken, and probable opportunities for nurses so qualified. The need for highly qualified personnel is as great in this province as in any other part of Canada but the facilities for securing the training are sadly lacking. Our nurses must travel hundreds of miles to reach a university providing post-graduate opportunities and, more sadly still, many of them avail themselves of positions in other parts of Canada when the course is completed. What can we Nova Scotians do about this situation?

Immediately following the first world war, the story was very different. A course in public health nursing was inaugurated at Dalhousie University in 1919, the first such course in Canada. But what happened? Due to a variety of causes, though the course continued for four years, the group of registrants be-

came smaller each year. The University was prepared to sponsor the course into its fifth year if twelve applicants were available but alas! there were too few and the course was withdrawn. That was twenty years ago and in all of that time it has not been revitalized. Why? With the great advances which have been made in preventive medicine and the ever-increasing demands for qualified public health nurses, is it not time the nurses of Nova Scotia began to think and plan for a reopening of this course at our own University?

Furthermore, have we in our province the opportunities for refresher courses and for keeping abreast of new developments in our work? Have we the necessary centre where institutes could be arranged? Are our educational requirements for entrance to schools of nursing of sufficiently high standard to permit any and every one of the students to qualify to enter the University? Is the course of instruction in our schools of



nursing of a uniform quality? What about our affiliations? Are they so planned that our students may benefit to the fullest extent? Have we the affiliations necessary for a full basic course? It has been stated that "The whole field of psychiatry has taken on a new meaning in recent years". Is this true of this field in Nova Scotia? What are we doing to help to meet the nursing needs of our mental and tuberculous hospitals, a need that is now greater than ever?

Let us consider our resources. We have ambitious students. In Halifax we have Dalhousie University, two modern, growing general hospitals, a communicable disease hospital, Children's Hospital, Maternity Hospital, Dalhousie Clinics, the provincial Pathological and Laboratory Departments, the Victorian Order of Nurses, the provincial and city Public Health Departments. Just across the harbour in Dartmouth are situated the Mental Hospital and the Polio Clinics. We have the tools, we have the students — have we the drive and enthusiasm necessary to put these together?

Yet another question — are we going to accept the challenge these questions present *and* enter the doors of opportunity?

RHODA F. MACDONALD

President

Registered Nurses

Association of Nova Scotia.

Stop Press!!!

All Nurses! Please Note!

An important bulletin from National Office, C.N.A. has been sent out to all of the provincial associations regarding the urgent need for the nurses of the Netherlands for assistance and how the nurses of Canada can help. Get in touch

with your provincial Registered Nurses office for information, to find out what is needed and how you can assist. Watch for a fuller story on this whole matter in the October issue of the *Journal*.

-M.E.K.

Beware of Fraudulent Agents!

Every once in a while letters are received from nurses who inform us they have not yet received copies of the Journal for which they paid "a man" the regular subscription price. Usually two or three months have elapsed since the transaction took place which makes it impossible to trace the miscreant who has duped the purchaser. Despite periodic warnings through these pages, many nurses still are not aware of the fact the

Journal EMPLOYS NO PAID AGENTS, that the local nurses' association has a Canadian Nurse convener who is delegated by the organization to collect subscriptions and who always forwards them promptly. Do NOT pay any subscriptions to itinerant agents. Do NOT accept any receipt other than the official receipt of The Canadian Nurse. DO subscribe to the Journal either directly or through the local conveners.

Plastic Surgery

ROBERT G. LANGSTON, M.D.

Plastic surgery is now considered a separate and distinct branch of general surgery. It has gained this recognition only after a long but steady march of progress during the past thirty years. It was during the first world war that a young British surgeon became interested in the terribly mutilating gun-shot injuries of the face. Other surgeons, frequently too busy but usually with the feeling that little could be done, were only too pleased to be rid of this type of case. Thus it was only a short time before this surgeon had a hospital of his own at Sidcup in England and had associated himself with men that are today outstanding in the field of plastic surgery in Britain, the United States, and Canada. During this time, he devoted himself to the care of the facial wounded and, since then, he has pioneered, persevered and perfected the science of plastic surgery. When the second world war broke out, this man, now Sir Harold Gillies, was the recognized doyen of plastic surgery of the English-speaking world.

Plastic surgery concerns itself, mainly, with surgery to the face, the skin and the hands. There is a common belief that it is primarily cosmetic reconstruction. This is not correct because the majority of work coming under this heading has little to do with what is popularly known as cosmetic surgery. This is especially so in wartime.

With the foregoing preamble, it is the aim of this article to describe briefly some of the procedures, and to point out some of the special nursing problems and techniques that are inherent in this branch of surgery. Just as other branches have developed special ways of doing things, so has the plastic surgeon, usually by the process of trial and error, found particular methods that give good

results. One also has to remember that the final appearance is important. Thus small details often assume importance both during and after operation. A few stitches incorrectly placed or allowed to remain too long may spoil an otherwise excellent piece of work.

In all cases, where healing takes place following an injury or operation to the animate body, there is one problem that must be met sooner or laterand that is covering the wound or opening by a permanent dressing. Now, it is rather significant that there is only one covering that is entirely satisfactory. That is normal skin. No other dressing will suffice permanently. Nature provides this ideal dressing for covering the body, and there is ample sufficiency for most emergencies. Should there be a large skin loss, as in an extensive burn, as a second best, nature slowly and grudgingly supplies scar tissue. But the price is high — contracture, loss of mobility and unsightliness. So far man has not been able to devise any artificial permanent dressing or covering.

There are several ways that skin can be transferred, by surgical means, to cover a deficiency. (It must be realized at the outset, that so far it has not been found possible to transfer skin from one person to another and make it grow permanently. Each person must provide his or her own skin). One way, and that most widely used, is Free Grafting. To do this the surgeon shaves off a layer of skin, not the full thickness, from the donor site with a special knife or dermatome. This graft is then transferred to the denuded place that needs covering. Here it is fixed so that it will not slide and held by an even pressure dressing. After the operation it must not be disturbed for four to eight days during which time it attaches itself to the underlying tissues and starts to grow. The new skin must be protected for some weeks during which period it is kept soft by gentle massage with lanoline. The donor area is dressed with an anesthetic ointment at the time of the operation and left ten days, by which time it should be healed.

In the case of large areas, as in burns, until recent years it was almost impossible to cover the entire defect. As a result, contractures occurred, limiting movement of arms, legs and of head. In some cases the patient became a cripple. Then to add to this state of affairs, in the early years of the war, the treatment of burns so advanced that patients with up to 60 per cent of their body surface affected were being saved. Previously, a 30 per cent burned person almost always died. Obviously, something had to be done, or these men - and there are a large number of them in wartime — would only be saved from death to become helpless cripples. After much trial and consultation it was found that grafting could be done much more extensively and sooner after the burn than was ever thought possible. Now, with modified techniques and instruments, it is quite feasible to remove 200 square inches of skin at a single operation and use it for grafting. This process can be repeated at monthly intervals using a different donor site at alternate sittings.

Another way to cover small defects that happen to be adjacent to an area that has an excess of skin, is by direct local shifts. By making certain incisions and undermining parts of the skin, it is possible to so arrange and stitch that the defect can be covered. The excess is thereby used to good advantage where it is needed. Examples of this type of shift are Z plastic, VY plastic and rotation flaps. There is no post-operative nursing problem, aside from maintaining dressings undisturbed.

A third way of transferring skin is by pedicle graft, either directly or indirect-

ly. The direct method can be used when the defect is on a mobile part of the body, such as a hand, arm, foot or leg. As an example suppose a finger has been denuded of skin. A flap of abdominal skin is raised so that the blood supply to the flap is maintained through its base. The free end is then sutured to the edge of the finger defect and the hand strapped in position on the abdomen. After two to three weeks it has acquired a new blood supply from the finger, so that the base of the flap may be severed. By the indirect method, a piece of skin is selected, usually on the abdomen. An incision is made along the opposite sides of the flap of skin undermined. It is then stitched in such a way to make it form a tube of skin attached at either end. This is allowed to remain about three weeks, at which time one end is cut loose and sewn into an incision in the wrist, so that it grows there. Another three weeks pass when it is ready to detach the other end from the abdomen. The wrist now supplies the graft with its blood supply, so that it may be carried to any part of the body to which the wrist can go, and remain in a comfortable position. It is sewn into the defect and there it remains with the wrist held by adhesive strapping for the third three-week period. Finally, the wrist connection is severed and the last end sutured into the defect.

This last method is very useful, especially when a graft is needed below the knee or over a bony prominence, in which position free grafting does not do well. The process sounds complicated and the nursing problems can be just as troublesome. Dressings are difficult until one has had experience in changing them. They require frequent inspection, to ascertain the condition of the skin with regard to blood supply. A close watch must be kept of the colour for the first twenty-four hours. Another problem is maintaining the awkward position for a prolonged period of time. This must be managed so that there is

no tension on the tube attachment. The involved joints become cramped and require massage and heat for the first few days to relieve the muscular spasm. It is the first few days, after each operation, that is so trying to both nurse and patient. Even with all of these disadvantages, the method is often used and it is becoming more popular. This is because the excellent final results in covering an area with pliable skin that cannot be covered by other methods.

A further word here about dressings in all cases. Infection of suture lines, of grafts and of flaps does a great deal of damage and can nullify weeks or even months of work and suffering. This type of case often requires frequent dressings or inspection of flaps. It is during these dressing changes that post-operative infection can, and does occur. A more or less general set of rules have been evolved to minimize the chance of-infection. Dressings are not taken down or changed during or immediately following the sweeping of floors, the changes of blankets or the making of beds, or other disturbance in the room. All attendants and the patient himself should wear masks covering the nose and mouth when the wound is exposed. No patient who has any exhibition of infection should be in the same ward or cubicle. Doctors and nurses who have any respiratory infection should not be in attendance.

Another branch of plastic surgery is that of the face. This includes fractures of the bones of the face and of the jaws. It assumes major importance in war surgery. Until recently, this type of wound was most unwelcome. A gunshot or an automobile wound of the face, with part of the upper or lower jaw involved, becomes infected almost immediately. Within twelve hours, untreated, it is a stinking, swollen mass. Often some parts of the lip are torn and missing as well so that the patient loses control of the saliva. This pours out continually and he is wet all the time.

If the lower jaw is gone, the support to the tongue is lost and it hangs over the neck, becoming dry and swollen. The patient suffers acutely from general discomfort, thirst, and later from hunger.

Thanks to a combination of recent developments, it is now possible to operate immediately. Anesthesia plays an important part. A routine of induction by sodium pentothal, bronchial suction, endotracheal maintenance using cyclopropane and oxygen, usually improves the condition of the patient greatly. After the operation he will wake up without vomiting and have a clear chest. As for the operation, repair is done first to the bony support, then to the mucous membrane lining of the mouth and tongue, and finally to the soft parts. If there is loss of skin, it is made good by grafting or by flaps. Broken bones are held by wiring, by pins or by dental splints. This closure of a dirty wound of the face has been made possible by the use of penicillin locally and intramuscularly, by the use of sulpha drugs, and by blood transfusions when indicated. After this is done the patient becomes quite comfortable, he is clean and dry, he can breathe without inhaling blood, and he can drink and eat. He still requires careful nursing. The mouth and face must be thoroughly cleaned, frequently and regularly. This is made easy and efficient by using a pressure atomizer and a weak hydrogen peroxide solution. Feeding is not such a problem if a bedside drinking cup has a short piece of rubber tube put on the spout. This can be introduced through any gap he may have in the teeth, back to the base of the tongue, and the patient soon learns to regulate the flow. Should the injury have involved the neck or have been a deep wound of the maxilla, with loss of the roof of the mouth, one must be constantly on guard for secondary hemorrhage for some weeks. The medical attendant should leave specific instructions as to procedure.

After the initial healing has taken place come the operations for reconstruction of the face. This secondary work can involve so many aspects of plastic surgery that volumes are written upon the different operations. It includes bone grafting, to replace a lost mandible, or a deformed nose or fill out a defect of the face or forehead due to loss of bone. A new concept of bone grafting that has been proven during the war years by a plastic surgeon in England, Mr. Rainsford Mowlem, is worthy of mention here. Instead of using the hard, cortical part of bone taken from the ileum, rib or tibia, as was the accepted way, he used only the soft cancellous core and packed it into place as small chips. The results were so much better than the old method that it is being used in other parts of the body, for bone grafting, by orthopedic surgeons. The results will be published in due time and it appears that the new method will make bone grafting a much safer and surer procedure. After the bony structure of the face is repaired, the soft tissue repair comes next. This may mean a new nose or part of one, new lips, eyelids or eye socket, or replacement of mucous membrane loss, as well as skin for any part of the face. Direct local shifts, pedicle grafts and free grafts are all used either alone or in combination. Finally, when everything that can be done by surgery is finished, it may be necessary to resort to artificial prostheses in the very badly disfigured. There is a promise, by the use of some of the forms of plastic resins, of making very lifelike noses or ears. These are light, of natural colour and consistency. When

necessary, these can be worn by the patient to give him confidence when seen in public, unobtainable by other means.

The last part of our subject is surgery to the hands. An immense amount of work during the past few years has gone into this complex branch of surgery. The results have been excellent where skin loss only has been suffered. Using thick, even skin, cut by a machine, called a dermatome, good covering to the burned hands can be achieved. However, where the damage extends to the tendons, the nerves or the joints, the prospect is not as bright. A good deal of progress has been, and one hopes, will continue to be made, so that in the future tendon grafting and repairing will give a higher percentage of successes. The main obstacle is providing a smooth sheath into which the tendon can glide after it has been repaired. So far no method has been entirely satisfactory. This will have to be found before one can expect to get a high percentage of successes in restoring contracted, immobile fingers and wrists.

Plastic surgery has made great strides in the past thirty years. It is possible that it should be called Reparative Surgery, to overcome the popular conception that it is cosmetic surgery only. It is built around the need of covering defects by skin, instead of scar tissue, and of transferring other tissues of the body — bone, tendon, fascia, etc., to fill defects or provide a lost function. It has evolved special techniques, concepts and instruments, to achieve success where, previously, it may have failed. Asepsis is particularly necessary to get good results.

Preview

The existence of mentally retarded individuals has taken on a new meaning in the past few decades since they ceased to be objects of derision and began to receive training and such education as their limited ability would permit. Dr. H. D. L. Goodfellow has discussed this changing philosophy in his forthcoming article on the plan for training defectives in institutions.

A School Health Service

G. LOVELL

School health service is one part of the total school health program of which the other aspects are generally stated as "health education" and "health environment". However, it is obvious that the three are so closely interwoven as to be almost indivisible. The entire program is participated in by all members of the school staff as well as by pupils and parents. The school health service is, however, usually regarded as that aspect of the health program which is primarily the responsibility of the "health specialists", that is, doctors and nurses, dentists and dental assistants, mental hygienists. The aims of the total health program may be taken to be: the development of pupils with sound physical and mental health, useful health knowledge and well-established health habits and attitudes, who will be able to conduct their lives with the greatest degree of satisfaction to themselves and usefulness to the community. The objectives of the school health service are: health education of individual pupils, teachers and parents; development of healthful habits and attitudes; maintenance of a healthful environment; discovery and correction of abnormalities - physical and mental; control of communicable conditions; care in accident and ill health.

In Toronto, the school health service is organized as part of a generalized public health program operated by the Department of Public Health. It includes service in all elementary and secondary schools supported by municipal taxation.

The district medical officers give medical service in the elementary public schools. They visit the homes of pupils of all schools for diagnosis of communicable disease. The elementary separate schools and the secondary schools are served by part-time physicians. The doctors visit their schools at regular intervals - weekly, bi-weekly or monthly. They act as consultants to the nurses. and teachers in matters pertaining to the school health program. They examine pupils in the first and seventh grades in elementary schools and in the entering and leaving years in the secondary schools. In the interval between these examinations pupils are examined who have been resignated as requiring observation and re-examination and pupils referred by parents and teachers because of some apparent need. There are many of these last so-called special physical examinations arising out of observation exercised by the teachers and encouraged by the nurses. Many special physical examinations are made in relation to placement in special classes for the physically handicapped - sightsaving, hard of hearing, open-air classes and classes for children with severe orthopedic defect. Parents are invited to be present at the examination of elementary school children. Their presence is helpful to the doctor and, of course, provides an opportunity for first-hand health education. Written notification of findings of the examination are given or sent to the parent who is advised, if there is any abnormality found, to consult a physician for further examination and treatment. A form is provided for reporting back as to the physician consulted and advice received.

Immunization against diphtheria and smallpox is carried out in the elementary school by a group of physicians and nurses who travel from school to school according to schedule, completing the work in one school before going on to the next. The Division of Quarantine notifies the school of exclusion and release of pupils quarantined as patients or contacts of pa-

tients having acute communicable disease.

Dental service comprises dental surveys annually in elementary schools, with dental clinics in thirty schools to treat school and pre-school children whose parents state that they are financially unable to secure private care. Dental service in secondary schools is limited to biennial survey. Notification of conditions found on survey are sent to parents.

The Division of Mental Hygiene of the Department of Public Health is under the direction of a psychiatrist and includes psychologists, a public health nurse supervisor, who acts as consultant to the members of the Nursing Division, a children's psychiatric worker interested in children presenting mental hygiene problems referred to her by the psychiatrist, two public health nurses who carry on psychiatric social work with girls attending the two senior auxiliary schools and a social worker concerned with girls who leave these schools. This Division is responsible for examination of retarded pupils and recommending pupils for "opportunity" classes for the mentally retarded and the senior auxiliary schools. They also examine and advise regarding pupils referred because of problems of behaviour or personality.

The public health nurses include health service in the schools in their generalized public health program. For administrative purposes, the city is divided into eight districts, each of these having a medical officer and superintendent of nurses and an average of fourteen staff nurses. Each staff nurse is responsible for the public health nursing service in her area with the exception of bedside nursing care which is given by the Visiting Nurse Organizations. During the school year the district staff nurses spend the greater part of the mornings in school where they commence their day at 8.30. They report in to their district offices at noon and with some

exceptions do not return to schools until the following morning. Schools are visited daily, or two or three times weekly according to their size and needs. The nurse's duties in school include preparation for and assisting with physical examinations; making appointments at school dental clinics; testing of vision of pupils in kindergarten and Grade IV; giving first aid in the event of accidents or emergency illness; interviewing and inspecting pupils previously noted as requiring supervision; seeing pupils who are referred to her because of apparent health problems. A time is set aside at the beginning of each day when the nurse is in the health service room for this purpose. Teachers are encouraged to make a morning inspection of their pupils so that they may note promptly any who presents signs of communicable conditions. Also, they are encouraged to observe their pupils closely from day to day and to bring to the nurse's attention any who show deviations from their customary appearvery rapid inspection of all pupils in the ance or behaviour. The nurse makes a elementary school at the opening of the September term in an area where there has been any occurrence of pediculosis, or minor skin infections, or where any one of the acute communicable diseases has been prevalent. She makes similar inspections of classes as occasion arises throughout the year. She plans for more leisurely inspection of all pupils at least once during the school year, preferably during the autumn term. At the time of this inspection a conference is held with the classroom teacher when the nurse and teacher consult their records of all pupils, exchange pertinent information concerning them, and plan together with reference to the teacher's program of health education and supervision in the classroom, and the teaching that appears necessary, or action which should be taken with reference to pupils' health habits or disabilities. Such class conferences with each teacher are

held twice during the school year and are invaluable if carefully planned and followed by appropriate action on the part of teacher and nurse. They do not, of course, obviate the necessity for conferences regarding individual pupils' problems or classroom health projects.

Conferences with parents in the school and visits to homes of pupils are an important part of the nurse's service. One of her chief functions is that of interpreter between the school, the home and other agencies. The nurse keeps a record of each pupil found to have a health condition requiring care or correction and takes steps necessary to bring about desirable action. Notification to the parent at the time of examination may be sufficient. It may be necessary for the nurse to clarify the matter further and to help the parent secure aid in order to overcome the disability. If the nurse in whose district the family lives is not the nurse in the school the child attends, they must be alert to keep each other informed. The school nurse gives all significant information from the school, and the district nurse passes on to the school nurse report of her visits in the home which have a direct bearing on the school child and, also, information which is sent her from the Hospital Health Service nurses of the Department who furnish information from the clinics and wards of the hospitals, from other Department sources, and from social workers.

The nurses visit the homes of pupils who are absent from school because of illness where there is reason to believe that the condition is one of acute communicable disease undiagnosed, or where it may be necessary to ensure that the pupil receives adequate medical, nursing and home care, extra-mural teaching or occupational therapy.

Auxiliary workers who are members of the Nursing Division assist the nurses in the control of pediculosis capitis. Four "matrons" work in the schools and homes where this condition is prevalent. They examine and treat pupils and demonstrate treatment to parents.

The details of service vary somewhat, necessarily, from school to school. Secondary school procedure differs from that followed in elementary schools. The nurse's function is, however, much the same throughout. She seeks to maintain and improve the health of pupils; she acts as liaison between the school, the Department of Public Health and the homes; and she uses every opportunity in schools and homes to teach health. Her primary function is that of education for wholesome living.

Citizenship and the Nurse

Arranged at the request of the Public Health Section of the Registered Nurses Association of Ontario, the School of Nursing of the University of Toronto announces a brief course on Citizenship and the Nurse from October 24 to 27 next. The enrolment fee is \$7.50.

The content as outlined will be presented by those prepared to deal authoritatively with the many phases of a subject both timely and challenging. The course, as a whole, will focus attention upon the significance and responsibilities of citizenship in the present day Canadian community: emphasis will be given the relation of the nurse, both within the hospital and in the community at large,

to current developments in community welfare. Within the general framework of the teaching, several periods will be devoted to the field of mental hygiene.

The general content of the course will be lectures on: (a) Citizenship and community welfare; (b) Citizenship and community health needs, including mental, social, and industrial health; (c) Certain factors which influence the attainment of community health: scientific research, housing and town planning, and health and social legislation; (d) Corporate effort for meeting the community's health needs: education, public welfare (health and social), and community machinery.

Why Girls Don't Go in Training

JEAN MASON

"The hours, study and amount of pay"—this answer, one of several answers of Canadian high school girls to the question, "What made you give up the idea (of nursing as a career)?", pretty well summarizes the reasons girls give for not choosing to enter the nursing profession. Let me correct at once, however, any impression this may give that the majority of girls are not interested in nursing. Of 566 girls completing questionnaires in a survey recently completed, 192 or 34 per cent plan to become nurses, more than plan to enter any other trade or profession.

The survey was made among girls in high school graduating classes, the purpose being to gather data on their interests, with particular regard to their interest in or feeling about nursing. Girls in various groups of schools across the country were presented with the questionnaire and instructed to fill in their spontaneous and voluntary answers. They were not required to sign their names, so it may be assumed that their answers were honest. A reading of the individual questionnaires definitely conveys an impression of sincerity.

Of approximately six hundred questionnaires distributed, 566 were returned, 391 from urban and 175 from rural communities. The percentage of rural population in Canada is greater than the returns show. Returns are most heavily weighted by the Maritime Provinces and British Columbia. The proportion of the population in Ontario and Quebec is also considerably greater than the proportion of questionnaires. The girls were asked what their plans were immediately upon leaving school, that is after summer vacation. Table 1 summarizes answers given.

The chief reason given by girls who named nursing as their first choice was the interest and appeal of the profession. Of the 566 girls answering, only fifteen did not know what they were going to do this Fall. Five hundred and fiftyone had a more or less definite idea of what they wanted to do after leaving high school. Table 2 summarizes reasons for choosing nursing or for choosing another career.

The various degrees of appeal of nursing are, from all data obtained, summarized as follows: 192 or 34 per cent

TABLE I

Plans for Fall, 1945

	Maritimes	Quebec & Ontario	Prairies	British Columbia
Number Answering	. 218	104	117	127
Pon't know	7	101	3	5
Nursing	84	18	12	15
University	40	48	20	37
Business course.	18	1	13	10
Teaching	13	8 .	9	10
University, then nursing.	4	4	3	9
Home economics.	8	1	3	7
Direct into office	6	3	1	8
More school	4	1	10	9
12th year, then nursing	g		1	
University, then teaching	4	3	î	1
University, then lab. technician	1	3	2	î
Selling	â	3		2
12th year, then home economics	4		e-mone	
Hairdresser	_			4
Miscellaneous (each named by less than 4 girls)	17	13	10	10

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	Nursing	All other careers
TOTAL MENTIONS	166	298
Interest and appeal	103	178
Idealistic	34	7
Better prospects	15	66
Best suited	11	21
Inspires respect	1	
Good future	1	
Teaches more of life	1	_
Miscellaneous		36
No special reason	26	64

named nursing a first choice (either by itself or in combination with university training, etc.); 68 or 12 per cent named nursing as second choice; 125 or 22 per cent had considered nursing a career but had given it up; 157 or 28 per cent had never considered nursing as a career; (the remaining 4 per cent do not state whether they had ever considered nursing). The reasons given by the 22 per cent for having given up the idea of nursing and by the 28 per cent for never having seriously considered it

— reasons why girls don't go in training — deserve careful study on the part of members of the nursing profession. These reasons are summarized in Table 3.

To obtain more information on the feeling regarding various aspects of nursing, eight phases of a nursing career — working hours, pay, student nurse life, recreational facilities, career opportunities, opportunities for marriage, effect on health and social standing — were listed, and girls were asked how

	for having up idea	Reasons for never having considered it.
Total Answering	125	157
No appeal		92
Prefer other career	14	9
Too much work	13	9
Dislike idea		21
Poor health	15	2 5
Long hours	7	5
Not suited	1	10
Don't like illness	_	10
Low pay	3	6
May still consider it	9	
Long training course	5	3
Too squeamish	_	5
Advised against it	4	1
Nurse surplus after war	3	1
Too expensive		4
No matriculation Latin	4	-
Dislike hospital	_	3 2
Rigid discipline	1	2
Too young	-	3
Poor future	2	
Coarsening	$\overline{2}$	_
No maths	2	_
No vacation.	-	1
No sports		1
Irregular hours	_	1
Never considered it		1
Never considered seriously.	1	
Family obligations	1	
Two nurses in family now.	1	

TABLE IV

	Good		FAIR		Bad		Don't Know	
Working hours Pay Student nurse life Recreational facilities Career opportunities Opportunities for marriage	Total Per 91 169 202 144 336	cent 16 30 36 25 60	Total Per 266 212 206 209 78	cent 47 37 36 37 14	Total Per 148 106 51 56 14	cent 26 19 9 10 2 5	Total Per 61 79 107 157 138	cent 11 14 19 28 24
Effect on health Social standing	195 388	34 69	213 92	38 16	81	14	77 79	14 14

they would rank each of these, whether they thought each of these phases of nursing good, fair or bad. Table 4 summarizes the answers given.

Table 4 also shows working hours and pay to be the aspects of nursing considered only fair or downright bad by the majority of girls. One girl emphasized her opinion on pay by the following marginal note: "Not only bad but very bad. How is anyone to live on ninety-three cents a month when in training?" The girl had apparently obtained this figure from her older sister who, as she had stated previously, had "gone through the hardship", and caused her to give up the idea of going into training. In answer to another question asking what information the girls would like on nursing, this girl asked, in ca-"WHY SO SMALL pital letters, WAGES?", and, also, incidentally, "Why such strict rules on hours to be in at nights?"

Among other elaborations on the matter of pay were:

Does not cover nurses' needs; not nearly enough for the hard work; bad for the amount of work; not enough to live on; have no money to have a good time on. Why is it that student nurses receive such small pay? If they have to buy hosiery, shoes, personal articles, and need money for recreation, you'd think they'd be allowed more than \$3.00 a month.

On the other hand, there was the girl who stated that she had "higher ambi-

tions" than nursing (that is, medicine or pharmacy) and who consequently thought a nurse's pay "good for that work"!

Less favourable than the feeling about nurse's pay is the feeling regarding work. The attitude toward this was revealed, not only in remarks on working hours, but also in remarks regarding effect of nursing on health, student nurse life, recreational facilities and opportunities for marriage:

You have to be very healthy to go in for such a profession. Bad for your feet and legs. One has to be fairly strong to withstand the labour. In some hospitals the nurses have too much night duty. Mother was a nurse and she says it was too hard work. Is a nurse job as hard and tiresome as I have been told? Not enough of your own time. One is too tired to go in for recreation to any extent. They have not much time or money to mix socially. Too tired to enjoy yourself.

On the other hand, again, we have the girl who considers the hardships of nursing a social asset. She ranks the social standing of nurses "good" because "if they choose the nursing profession, they're brave"! And there's the girl who says of a nurse's working hours that they're "rather awkward but nothing to complain about in these times", a statement that some graduate nurses might do well to bear in mind.

Attitudes on the effect of nursing on the health are sharply divided between those who feel that the effect is "good" because nurses "should know how to take care of themselves" and those who feel that the effect is "bad" because, as one girl puts it, "some of the things you communicate with are not suitable". Another girl carefully considers the matter and renders her verdict: "If you're in good health, I don't think nursing would necessarily ruin it".

There is less knowledge about recreational facilities than about any other aspect of a nurse's life. A general opinion is that nurses are too busy or too tired to avail themselves of recreational facilities. One girl says briefly: "Getting better — but —".

There is a division of opinion regarding student nurse life. Some rate it "good", largely because of the association with other girls with the same interests; others rank it only "fair" or "bad" because of the amount of work to be done and the rigid discipline, (although, surprisingly enough, several girls rate it "good" because of the discipline). Here are some sample opinions regarding student nurse life:

Not enough of your own time. Not enough friendliness among nurses for students. Watched too carefully. Nurses seem to get on together well. They are well disciplined. Bad (conversations with a nurse). Girls all seem happy.

Opportunities for marriage are generally considered good, although some girls feel that a nurse hasn't the time to find herself a husband (unless, of course, she can grab off a near-at-hand doctor or patient!). On the pro side are:

Nurses all marry well. There are internes (male) around. "Good" because "all nurses spend some time with babies and have experience with children". "Good" because "have medical experience". You have a good base for the home. You could marry doctors, which would be a credit. "Good" because

"most people admire nurses". Patients and doctors around.

And on the con side:

Too busy. You usually give yourself completely to this type of a career. Most nurses that are married seem to be middle-aged. Too tired to enjoy yourself.

This girl probably has the right answer: "Same as other professions — depends on self". And this lassie, we hope, will never have a rude awakening: "Opportunities for marriage — good — aren't they always?" Career opportunities and social standing are almost unanimously considered good.

Feeling about opportunities in nursing is summed up in statements like the following: "A nurse is always needed". "Always work for a nurse, especially after this war". "New fields of nursing developing".

In a survey recently made in the United States it was found that many did not find nursing "socially acceptable". It is heartening to note that there is little of this attitude in Canada. Most girls seem to feel that high social standing is the nurse's reward for hard work and sacrifice:

Others respect nurses who care for the sick. (Nursing) gives you self-assurance. Everyone feels proud to know a nurse. Invited to many socials. (Nurses) seem to go places where other people do not. (There might be some doubt about what this would do for their social standing, but the writer of the statement rated social standing "good").

There are a few girls who aren't so sure about a nurse's social standing though. One girl says, with a rather obvious sneer: "Anyone can go in for it". Some girls somewhat misconstrued the meaning of the question, making statements like this: "You can't be into social life out of the hospital".

One girl answered the question regarding social standing with the simple statement: "Nursing is a profession".

In breaking down attitudes toward various phases of nursing into provinces, we find the attitude toward working hours best in the Maritimes, worst in Ontario and Quebec: the attitude toward pay overwhelmingly best in the Maritimes, overwhelmingly worst in British Columbia; the attitude toward student nurse life and opportunities for marriage best in the Maritimes, worst in British Columbia; the attitude toward recreational facilities best in the Prairies, worst in Ontario and Quebec; the attitude toward career opportunities best in the Maritimes and British Columbia; the attitude toward effect on health best in the Maritimes, worst in Ontario, Quebec and British Columbia: the attitude toward social standing throughout.

In considering attitudes of urban versus rural girls, we find that the attitude of rural girls is generally more favourable.

The big reason, as shown on a previous table, for girls not seriously considering a nursing career was "no appeal". The reasons why nursing has "no appeal" to these girls have been pretty well revealed in their attitude on the various phases of nursing as above discussed. Some miscellaneous statements give the sentiments of smaller groups:

Can't stand hospitals. Can't stand the sight of blood. Not interested in sick people. Can't stand to see people vomit. Blood makes me sick. Work is too depressing.

The survey from which the above and much other information was obtained is, to the best of our knowledge, the first of its kind made in Canada. The 566 replies, spontaneous and unrehearsed, are as entertaining as any novel. But the survey was not made for entertainment purposes. It was made to help us in our efforts to attract the best of young Canadian womanhood to nursing. To show us, among other things, what these young women don't like about nursing. To enable us to examine their criticisms, and, where necessary, endeavour to make improvements. The survey is a beginning. It will prove valuable to the extent to which we make it valuable. Now we know. Let us act.

Recovery

NURSING SISTER RUBY G. HULL, R. C. N.

A little over a year ago, due to the increasing amount of major surgery and a changing nursing and sick berth attendant staff, it was appreciated by anesthetist, surgeon and nursing sister alike that immediate post-operative care could be more efficiently carried out and a good many problems overcome by the institution of a special department known as the post-anesthetic Recovery Room.

A suitable location, a large five-bed cabin, on the same floor as the operating room was chosen. This room was furnished with resuscitator, oxygen tank, suction apparatus, bed-side tables, electric fan, intravenous standards and two cabinets — one for sterile supplies, plasma, intravenous equipment and solutions, the other with hypodermic tray, mouth and rectal thermometers, stimulants, sedatives, mouth gags, tongue

forceps, airway, stethoscope and blood pressure cuff, etc.

The head of the department is our chief anesthetist, Surgeon Lieut, Cmdr. Stoddard, R.C.N.V.R., and two nursing sisters comprise the staff. Our day begins with a check-up on the previous day's patients who have had spinal, inhalation, and intravenous anesthetics. This is of great importance to the anesthetist, for if headaches have occurred or the patient shows signs of upper respiratory infection, elevated temperature or respiratory difficulties, he will visit them before his morning's work begins. "Spinal" headaches are treated after the blood pressure has been taken, in the usual manner of elevating the foot of the bed, placing ice caps to the patient's head, giving sedatives, intravenous therapy, pituitrin and, in some cases, a spinal puncture to lower cerebro-spinal fluid pressure. Those showing upper respiratory infections and symptoms of atelectasis are held firmly over the diaphragm and encouraged to breathe deeply and cough. This proves most effective, for in a very short time the patient is coughing up retained secretions, and respirations that have been shallow and laboured become deeper. The colour improves as the lungs reexpand and a possible pneumonia will have been averted.

We then prepare for our day's work and, having reviewed the list of expected patients, we ask the various wards to send along the anesthetic beds with extra equipment, such as shock pins, hot water bottles and one pillow. Many times ice collars, ice bags, drainage bottles, bed cradles, fracture boards and extra pillows are needed and are requested.

The first patient usually arrives in the Recovery Room at 9.30 a.m. and from then on we are kept busy. Blood pressure, pulse and respiration are recorded every fifteen minutes during the first hour and then every half or one hour as indicated. Except when ordered

otherwise, the unconscious patient is always maintained in the lateral position, and in our oral surgical cases particularly, the use of nasal and oral suction is of great benefit in keeping the respiratory tract clear from aspiration of blood and mucus.

An outline of the Recovery Room responsibilities can be briefly summed up:

- 1. Starting of intravenous and oxygen therapy.
- 2. Introduction of duodenal tubes and Wagensteen suction.
- 3. Administration of sedatives and stimulants.
- 4. Constant watching for hemorrhage and shock and following plaster casts, warmth or discolouration of fingers and toes.
 - 5. Reinforcement or changing of dressings.
- 6. Frequent changing of position and explaining to the patient why this and deep breathing are beneficial to them.
- 7. Sympathetic understanding and allaying of fears and apprehension.
- 8. Full or partial sponge bath, back massage and changing of bed linen before being transferred to ward.

Many times the very ill or shocked patient is kept in the Recovery Room overnight with a special nurse. But more often he is sent to a private cabin, leaving the Recovery Room free for the use of survivors and accident cases admitted during the night.

In closing, may I stress the importance and essentiality of close co-operation with the various departments. During a busy day with ten or twelve patients going through our department, a condition which is becoming more the rule than the exception, it is increasingly evident that we could not function successfully without it. There prevails Assistants, the Ward Medical Officers and Ward Sisters, the Sick Berth Attendants, and the staffs of the Central Supply Room, Operating Room, Dispensary and Recovery Room, a sympar

thetic feeling, a broad understanding.

We feel that this new department has been of great help in the prevention of post-operative complications, and an added safeguard in the treatment and care of those who fight for us.

DDT Studied for Outdoor Use

Extensive investigations are now being conducted to determine the benefits and possible hazards involved in the contemplated use of the insecticide DDT on a large scale outdoors as part of a plan to control insectborne diseases. One of the largest tests to date is scheduled to commence in the Lake Nipigon area north of Fort William, in an attempt to check the spread of the spruce budworm which is threatening to destroy valuable stands of timber.

DDT was rushed to Naples in the spring of 1943 when typhus threatened to reach the proportions of an epidemic. Military authorities on typhus control took over and daily some twenty thousand persons, rich and poor alike, were dusted with DDT. Over two million people were so treated. Soon the decline in the incidence of this louseborne scourge was as abrupt as its rise had been steep. For the first time in history, a typhus plague had been arrested in midwinter. In South Pacific areas, where Allied troops were waging a grisly war with the Japs, not the least of the killers turned out to be malaria. Here the story of DDT was equally dramatic and equally effective. When Allied troops had to fight their way from island to island, with supplies of quinine at a very low ebb, the spraying of DDT proved fatal to all the mosquito types transmitting this dangerous disease.

DDT is a chemical compound which was discovered in the 1870's and, like many other products of scientific research, remained nothing more than an idle curiosity until 1939. The reports of DDT thereafter read like fairy tales. DDT — or dichlorodiphenyl-trichloroethane, to give it its full name — proves relatively harmless to man and animal, but is a tested killer of many

household insects, many of the innumerable varieties of insects which prey upon crops, and of many types of blood-sucking insects responsible for the spread of disease in animals and man. Its fatal action is said to be equally certain whether the insect ate the drug or simply touched it. As a film on surfaces, it is reported to be effective for weeks at a time.

DDT is effective in solution, or when used in a dusting powder. Readily soluble in many solvents, it is possible to disseminate clouds and sprays from the air as well as from the ground. On interior walls, DDT has been shown to retain the lethal effect for as long as three hundred days. As a spray in solution, it not only kills insects on immediate application, but continues to kill for months. Applied in solid form, it readily kills body insects.

Only recently has DDT begun to come on the market for general purpose use, and even yet is being restricted by the Director of Pesticides for Canada this year to stable spraying, food packaging establishments, for hospitals, etc. None is yet available to the ordinary household for fly sprays. The householder will welcome its protection against the common fly and hungry mosquito, as well as the destructive moth.

Besides killing insects that carry diseases, DDT may kill other insects that are beneficial, and thus affect the balance of nature which is important to agriculture and wild life. In combat zones, where the health of the soldier was at stake, it was necessary to ignore these considerations but general outdoor applications will not be adopted until more is known about these biological effects.

-Dominion Rubber Co. Ltd.

Victory Scholarships

The Royal College of Nursing has announced that, in token of victory, and in appreciation of the work of hospital ward and departmental sisters throughout the war, forty scholarships of fifty pounds each were to be awarded under the Halford Bequest to provide two weeks travelling instruction and two weeks holiday.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses
Association

Room to Grow In

HELEN G. McARTHUR

Out on the prairies the citizens boast of the wide open spaces. They glow with pride as they take a visitor to a small hill and point ahead saying "There to the South you can see the elevators of three towns rising from a sea of wheat; to the East the road winds its way for some twenty miles, to the North are more elevators, while to the west lift up your eyes to the Rocky Mountains standing white-capped and majestic against the sky." There is always an infinite variety. You just cannot feel hemmed in, because there is room in which to move and breathe. You can see where you are going and you know there are still new frontiers to conquer. It's a glorious feeling - that feeling of room to grow in, and opportunity ahead.

As chairman of the Public Health Section of the Canadian Nurses Association, I feel the same exhilaration when the reports of the Provincial Sections come in and we sit down to review what is happening in public health nursing in Canada. Some of the details of these new developments will be presented next month by our secretary for your information and inspiration. Looking over the activities of the Provinces we can see new programs in industrial nursing; the growth of closer relationships with undergraduate students in our training schools; a broad expansion in the establishment of full-time public health services to rural Canada: the expression by the general public of a deep and sincere respect for public health nurses and what they are trying to do; and an ever increasing army of well qualified young nurses working earnestly and intensely that they may achieve the best for themselves and for those they serve. It is thrilling to see that public health nursing in Canada today has that feeling of room to grow in and opportunity ahead.

There is also evidence that public health nurses are not satisfied to have it said of them "She is an efficient public health nurse." They want much more. Nurses are preparing themselves so that it may be said of any one of them, "She is a charming woman, a valuable citizen and an efficient nurse." And in that order too.

Looking in the mirror in the early morning one realizes that the beautician, the right dress shop, and getting to bed earlier are certainly essentials for the charming woman. Miss Deming pointed this up in her well-directed remarks to the medical officers of health at the 1944 meeting of the Candian Public Health Association. However, most women are aware that to be attractive looking helps in making the first impression but much more is needed to sustain us through a lasting impression. Nurses are being entrusted with an important social responsibility in

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plans for the future of Canada. We are beginning to realize this — but it is important for this feeling to be strengthened

by knowledge and by action.

Mrs. Margaret McWilliams, chairman of the sub-committee on Post-War Problems of Women, Dominion Government Committee on Reconstruction, at the biennial meeting of the Canadian Nuses Association² gave us inspiration and some principles to help us develop a broad interest in the world about us and for individual growth.

The report of the sub-committee on Post-War Problems of Women gives nurses broad views on how to function effectively as women and as citizens. This report has also challenged nurses to meet some of the needs of Canadian women we have hitherto failed to accept although we are equipped to do so. The report states that during wartime women have played their full part as responsible citizens and they expect to continue to be treated as such in the coming years. Their hope is to be full members of a free community.

Public health nurses are particularly fitted to give leadership because they have had peculiar opportunities for the development of their professional status through the social significance of their work and the lack of competition from men in the nursing field. Cognizance must be taken of the fact that the achievements of women during wartime will remain and become permanent only if the work and sacrifice of the years to come match those years in which work and sacrifice seemed the natural thing. "One continual need will be sympathy

and understanding among women", says the McWilliams report. "Without it there will be little hope of happy solutions of the post-war problems of the women in whose lives war has made fundamental changes. Certainly there must disappear from among us that indifference — indifference which at times becomes antagonism — of women to women. There is no need to think of aggressiveness or antagonism on the part of women towards men or vice versa. We are not antagonistic but, as war work has shown, complementary. Our responsibility to the country and our work is often different in kind and almost always different in emphasis. Our country needs all that both men and women can give if our post-war problems are to be solved and a beginning is to be made in Canada in the building of what we like to think of as 'the brave new world'."

Does not this statement challenge us to act as women and as citizens as well as to fulfil our professional responsibilities? As chairman of the Public Health Section of the Canadian Nurses Association, I feel I, too, can say of public health nursing that there is always an infinite variety. You just cannot feel hemmed in, because there is room in which to move and breathe. You can see where you are going and you know there are still new frontiers to conquer. It's a glorious feeling—that feeling of room to grow in, and opportunity ahead!

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Preview

Much has been said and written regarding the usefulness and necessity of a secondary group to assist professional nurses in meeting the demands for nursing service. An eminent physician, Dr.

J. C. Meakins, dean of the School of Medicine at McGill University, has presented his opinion on this topic in "The Future of Nursing". Do you agree with his hypotheses? Watch for this article.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A.

Conflicting Ideas in Textbooks

A. E. HAGGART

One of the most difficult problems faced by an instructor is to determine, from the conflicting statements in the standard textbooks used in our schools of nursing, which are correct, which should be taught. If it is hard for the instructors to reconcile such divergent facts, how much more confusing must it be for the students? One of the commonest sources of these apparent discrepancies is found in the texts used in Materia Medica and Pharmacology, Referring to the use of disinfectants there is a variation in both the amount required and the length of time the solution must be in contact with infected material. From several wellknown books, I have selected the following statements dealing with the use of formalin:

Text 1. "A 10 per cent solution is added to excreta and allowed to remain in contact with it for one hour".

"Linen — 10 per cent formalin — one hour".

Text 2. "Formalin is used chiefly for the disinfection of excreta... An equal amount of 10 per cent solution should be used and allowed to stand for one hour", and "Bowel discharge may be disinfected by . . . 10 per cent formalin solution, in volume equal to that of the material to be disinfected, the mass thoroughly mixed and allowed to stand for two hours before disposal".

"Soiled sheets and clothing may be immersed in a 5 per cent solution for one hour", and "Sheets . . . may be disinfected by . . . 10 per cent formalin for two hours".

Text 3. "Feces can be deodorized and disinfected by the addition and thorough mixing of a 10 per cent solution of formaldehyde" . . . "Solution should act for at least two hours . . . desirable to use an excessive amount".

"Linen — solution of formaldehyde 10 per cent",

Which is sufficient — a 5 or 10 per cent solution? Since the germicidal efficiency of any solution depends largely on its strength, this difference in suggested disinfectants is important. If the lower concentration is effective, in the interests of economy one would use it. The length of time the solution is in contact with the infected material is also important. If one hour is sufficient why leave it for two? Furthermore, formalin is a 37-40 per cent solution of formaldehyde. How then, can they be used more or less interchangeably?

Similar confusing statements are found concerning phenol and its uses. In one textbook varying strengths of solution are indicated for disinfecting purposes:

"Used in 5 per cent solution to disinfect sheets, etc." "Used in 2 to 5 per cent solution for stools and urine". "The articles must be soaked in carbolic acid for a half hour to several hours". "In weak solutions, 2 to 5 per cent, it checks the growth of all bacteria except their spores which are resistant forms. It is the most efficient antiseptic known".

If a 2-5 per cent solution is only antiseptic how can it be used to disinfect? Why should linen require a higher concentration than excreta? Some species of organisms may be destroyed in half an hour but can we expect a student to remember the varying periods of time for the different species? One cannot burden a student with too great detail because she becomes confused she has too much on her mind. Would it not be wiser to give one strength of a drug and a definite length of time which offers a wide margin of safety? Probably several drugs are efficacious in the space of an hour. Then, allow one hour as a standard time. Surely, sufficient experimental work has been performed for clearer ideas than are expressed in present-day texts.

Consider these remarks as further evidence of the contradictory statements regarding phenol recorded in approved texts:

Text 2. "Do not give glycerine or oils umless they are afterward removed, as they promote absorption of phenol".

Text 3. "Olive oil may be left in the stomach to retard absorption and to act as a demulcent".

Both of these statements cannot be true. Might it not be wiser to indicate controversial opinions and not make definite statements if the true facts are still in doubt?

Chlorinated lime is an efficient germicide for use in disinfecting excreta safe for use in any home and easily obtained. Student nurses are bound to be confused when they read in one of their texts:

"Its chief use is to disinfect infected material such as feces and other excreta. A 5 per cent solution is suitable for ordinary use. To disinfect excreta equal volumes of excreta and 1:5 solution should be mixed thoroughly and allowed to stand for one hour".

Is the "1:5" a misprint or is a 20 per cent solution actually what is meant? Or may there be confusion with the strength of slaked lime which is used as 20 per cent for the same purpose?

Even in the definition of terms in our dictionaries and glossaries, authorities do not agree. Consider the following: "Infarct — an obstruction or embolus: the morbid condition of a limited area resulting from such obstruction". An obstruction or embolus certainly is not the same as the condition resulting from it. Again, the majority of authors on obstetrical works consider the puerperium: "The period from the termination of labour to the complete involution of the uterus". However, we do find: "The puerperium is the period from the beginning of labour until the genital organs and tract have returned to their almost normal size and condition". Needless to say these are not the same and students must be confused by such definitions.

Instructors and students desire reliable information. Examiners often must be in a quandary. Can we not have greater uniformity in our ideas so that all of us may benefit?

Hypothyroidism

One of the most helpful diagnostic clues in hypothyroidism is tolerance to heat. The patient whose hands and feet are always cold, who does not mind hot summers, and who needs heavier clothing than her friends and heavier bedclothes than her husband, is very likely to be hypothyroid.

-Physician's Bulletin.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

Ruptured Spleen

EDITH WELDON

On November 1 at 7.30 p.m., James, a young lad of fifteen years of age, was admitted to Victoria Public Hospital, Fredericton, suffering from severe abdominal pain due to an accident, which he had had earlier in the day when he was thrown from a bicycle. When admitted the patient was suffering from severe shock. While the doctors were attempting to make a diagnosis, the foot of the bed was elevated, and hot water bottles and a baker were applied to counteract the shock, X-ray films were taken at once; they were of value chiefly from a negative aspect they revealed no broken ribs, no pneumothorax, no shift in mediastinum, no free gas. Urinalysis was normal, red blood cells 4,020,000 per cu. mm. white blood cells 23,200 per cu. mm., hemoglobin 72 per cent. After consultation, the doctors decided immediate operation was imperative. When the abdomen was opened, considerable blood was found in the peritoneal cavity, and many clots about the spleen. The spleen is a soft pliable organ lying mostly in the left hypochondriac region, and at the tip of the pancreas. Although its detailed function is not known, it plays an important part in the destruction and regeneration of red blood cells. One edge of this organ was found to be badly torn and contused. At this stage the patient's condition was poor, so three

yards of packing gauze were placed about the spleen, and the abdomen closed.

Immediately upon his return from the operating room, James was placed in a specially prepared (anesthetic) heated bed, and received a blood transfusion of 500 cc. together with 400 cc. of 5 per cent glucose in normal saline intravenously. His pulse was 140-160 and very weak; gradually it became a little slower until by morning it was 124 and of fair volume. By this time he was suffering from extreme thirst and nausea. but no emesis. He was given 1,000 cc. of 5 per cent glucose in normal saline intravenously twice a day for the first six days. From the first the patient did not complain of extreme pain, but more or less general discomfort and restlessness. Morphine sulphate grs. 1/4 Q. 4. H. p.r.n. was given as a sedative.

During these first three days his temperature ranged between 99° — 103°F., he was taking fluids freely; his abdominal dressing required changing occasionally due to a moderate sero-sanguinous drainage. On the third day the patient's condition became critical, his skin was cold and clammy, his abdomen was very distended, he was nauseated with emesis of brownish-green fluid, and suffered intermittent attacks of hiccoughs. A Levine tube was inserted with immediate suctionage of 600 ce. dark brownish fluid. Within a few

hours the abdomen was definitely softer, and the patient's general condition slightly improved. A soapsuds enema caused expulsion of considerable flatus, but very little fecal matter. At this time the red blood cells numbered 3,-290,000 per cu. mm. His pulse was still 140-160. However, within a few days he was taking a soft diet and having bowel movements daily.

On the eleventh day the patient recommenced to vomit, there was increased drainage from the abdominal incision with a slightly disagreeable odour, the abdomen was distended in spite of the passage of flatus per rectum. At this time the white blood count was 44,500 per cu. mm. The Levine tube was reinserted for relief of distention. Soluthiazole 5 cc. was given intravenously, or intramuscularly O.4.H. for three days, then Q.8.H. for three days. One yard of packing around the spleen was removed, and two days later the other two yards removed, with no bleeding whatsoever. The patient's condition showed little change; carminative enemata were effectual; temperature was 102°F., pulse 160, respiration 32.

On the fourteenth day the application of hot stupes to the abdomen Q.4.H. was begun, and penicillin therapy was started - 15,000 units Q.3.H. intramuscularly. Intravenous infusions, 1,000 cc. of 10 per cent glucose in normal saline, were given twice daily. Water was taken freely, and in the water was dissolved Dexin - a preparation of dextrose supposed to produce a minimum of gas in the gastro-intestinal tract. The abdomen remained rigid and tight with a definite fullness over the bladder region, which led us to believe that the lad had a full bladder. By means of a rectal examination the doctor discovered in the pelvis a mass about the size of an infant's head. The patient's condition was poor, and the doctors considered that the operative risk was too great, so decided to continue the treatment as outlined.

On the seventeenth day the patient complained of a definite tightness in the abdomen, and later there was a sudden gush of sero-sanguinous fluid (with no odour) from the abdominal incision. The dressing and bed were saturated it is estimated that at least 1,000 cc. of fluid was discharged. Pulse and temperature were unaffected by this outburst, but the abdomen was much softer. On the next day there was another gush of discharge from the incision, this time of a purulent nature with a slightly disagreeable odour. The temperature gradually returned to normal, and the penicillin was discontinued after nine days' administration. The red blood count, hemoglobin, and urine were normal. However the pulse rate remained elevated at 112-120.

During these two weeks, the patient lost considerable weight and his appetite was poor. His diet had consisted almost entirely of fluids: water with Dexin, gingerale, orange juice, chicken broth, etc. After the nausea had stopped other foods were added: toast and tea, cream soups, and soda biscuits, ice cream and cookies. Gradually he was being given a full diet, but his appetite remained poor and he ate very little. Every effort was made to prepare and serve favourite dishes, such as an oyster stew and clam chowder, but nothing seemed to stimulate his appetite to any extent. So, after thirty-seven days in hospital, our patient was taken home by ambulance. He was not completely cured, but it was thought that his convalescence would be more satisfactory amidst the familiar surroundings of his home. However, even then, the troubles of our long-suffering patient were not over. A few days after his arrival home, he was subjected to the discomfort of an impacted rectum, which developed in spite of the fact that he had a daily bowel movement. After that, his recovery progressed satisfactorily and he is now able to participate in many activities.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

Reports of Committees

The following summaries have been prepared from reports of various committees presented to the Executive Committee on May 31, June 1 and 2, 1945:

Committee on Nursing Education

At the meeting of the committee on Nursing Education in Montreal on October 27, 1944, the following resolution was passed:

That the committee on Nursing Education recommend now to the Executive Committee of the C.N.A. that the following arrangement be made to facilitate the work of the Education Committee in the present biennium —

- (a) That appointment be made to full membership in the Education Committee of at least four persons who reside in the same town with the chairman of the Education Committee; these to be chosen from the C.N.A. membership at large and not because they have been selected already for some other C.N.A. function.
- (b) That the convener and the conveners of the two sub-committees with the above four members, be considered as an executive sub-committee of the Education Committee, and that this proposed executive sub-committee be given power to act.
- (c) That when possible the remaining exoficio members of the Education Committee be notified of all meetings and attend when possible, and that, when they cannot attend meetings, they be considered as corresponding members and thus receive information of all action taken by the proposed executive sub-committee.
- (d) That a Vice-Chairman be appointed. (Secretary assumed.)

Nurse Practice Acts

Following the report of the subcommittee on Subsidiary Nursing Groups to the meeting of the Executive Sub-Committee on March 27, the following motion was passed:

That the provincial associations be urged to take immediate steps to obtain Nurse Practice Acts, which will include both professional and assistant nurses.

Hospital and School of Nursing Section

The special page in *The Canadian Nurse* has been very active, and the convener has on hand sufficient material for each month until November. Throughout the provinces, studies have been made of placements, courses in the curriculum, staff education, ward teaching, examinations for the admission into associations of registered nurses, training school records, refresher courses for instructors, etc.

The following suggestions were submitted from this Section for the 1946 biennial meeting: (1) use of pre-testing in the nursing school curriculum; (2) use of tests and measurements; (3) staff education program and ward teaching.

A short institute on one of the above topics would be of great value, if such could be arranged during convention week.

General Nursing Section

This section stresses the need for greater unity, for more active partici-

pation in Section and Association activities by the individual private duty and general staff nurse.

The Placement Service is proving its worth, especially in attempting to meet the needs of rural hospitals. The calls for general staff nurses for sanatoria and mental institutions still far exceed the supply. Salaries for general staff nurses have been increased in many instances and more attention is being paid to living conditions. Plans are again being made to supply summer relief.

Public Health Section

The National Section executive feels that a definite effort should be made in the provinces to include industrial nurses in the public health sections. Therefore the following resolution was passed and sent to each provincial public health section:

That an attempt be made in each province to organize the industrial nurses as a subsection of the Public Health Section under a similar plan as exists in British Columbia.

In British Columbia the industrial nurses have formed a sub-section of the Public Health Section, and the chairman of the Public Health Section attends their meetings. Any resolutions from the industrial nurses are brought through the chairman of the Public Health Section to the Council of the Registered Nurses' Association of British Columbia.

The Education Committee has been working on a follow-up study on "The Use of the Volunteer in Public Health Nursing" and reports that questionnaires and reprints of the report on this subject, as found in the December, 1943, issue of the Canadian Journal of Public Health will be mailed to each provincial section.

The Publications Committee has been very busy procuring articles for the Public Health Nursing page of *The Canadian Nurse*. Material is arranged

for up until a Fall issue. At the last Executive meeting the following resolution was passed:

That each provincial section should be made responsible for contributing one article, at least, by September 1, on some interesting public health project in their respective provinces.

British Nurses Relief Fund

Funds continue to come in from the provinces. Because of the increased air bombing during the latter part of February and early in March, it was decided to send a further donation of \$5,000 to Great Britain. A letter of thanks has been received from the Royal College of Nursing for this amount.

National Bursary Award Committee

On July 19, 1944, the National Bursary Award Committee met to consider 164 applications. Out of these, 115 long-term bursaries and 13 short-term awards were made. Further awards were made up to June 10, 1945, until the total number of long-term bursaries reached 125 and the short-term bursaries numbered 72; 63 applicants received assistance with travelling expenses. Of the allocation of \$75,000 for bursaries, the division was as follows: long-term bursaries, \$60,000; short-term bursaries, \$10,000; travelling expenses, \$5,000. All but \$15 of this amount was used.

Study Committee for Nurse Representation on Dominion Health Council

A review of the correspondence on file shows that it is over twenty-one years since the C.N.A. made its first approach to the Dominion Government requesting that a representative of the C.N.A. be appointed to the Dominion Health Council.

In July, 1943, a formal request was submitted to the Honourable the Minister of Pensions and National Health by the C.N.A., namely:

That, as the Dominion Health Council deals with the health matters with which the nursing profession is most vitally concerned, a well-qualified, experienced nurse be appointed as a member of the Dominion Health Council.

The Minister expressed appreciation of the interest of the C.N.A. but stated:

It is felt at the present time that it would not be warranted to increase the membership or change the type of personnel forming the Council in view of the success of its operations under existing conditions.

It is felt by Canadian nurses that this request has scarcely received the consideration it deserves. It has been pointed out to the C.N.A. that other professional organizations are not represented on the Dominion Health Council as such. This fact is recognized but it does not seem fully relevant or convincing. It is admitted, too, that the C.N.A. has continued to present this request to the Government for over twenty-one years. Nevertheless, other worthwhile achievements have taken as long; therefore, it has seemed advisable that the importance of having nursing representation on the Council should be kept before the authorities in the hope that something can be done about it.

Editorial Board

The Editorial Board was first named after the Winnipeg meeting last year. The responsibilities of the Board are broader than its name would indicate, for they include financial matters as well as editorial policy.

The Journal is owned and published by the Canadian Nurses Association. When a full-time editor was first appointed in January, 1933, it was stated that the Canadian Nurses Association would be responsible for any deficit. The present budget of the Journal is approximately \$25,000 and the prospect of a deficit is most unlikely. It appears wise, however, that the financial

policy as it relates to *The Canadian Nurse* be clarified as a guide to the Editorial Board now and in the future.

Since the present editor assumed office and the Editorial Board was named, it has been the practice to refer any extraordinary expenditure, not included in the budget, to the Editorial Board for approval, and then to the Executive Committee of the Canadian Nurses Association for ratification. The new salary scale for clerical staff which was adopted this year provides an example of this method of dealing with financial matters. The procedure seems logical and satisfactory, and it is now recommended that this practice be adopted as a definite policy to guide future financial relationships between the Canadian Nurses Association and The Canadian Nurse.

Exchange of Nurses Committee British Civil Nursing Reserve

One meeting of the sub-committee of the Exchange of Nurses Committee has been held since the Executive last met. At this meeting, a letter was read from Miss Watt, of the Ministry of Health, London, Eng., stating that, in view of the developments of the war situation, further recruitment of Canadian nurses for the British Civil Nursing Reserve should now be discontinued. Applications of four nurses, which were approved by the convener in September, were ratified; three of these nurses had already left for overseas. When it was found that passage had not been booked for the fourth nurse, she was advised of the discontinuance of recruitment.

Reports from Miss Watt concerning the fifty-three nurses who have proceeded overseas are for the most part very satisfactory. We have been notified, however, that twenty-seven nurses have severed their connection with the Reserve — nine due to pregnancy, four having completed the full year of service, four having been released to return to Canada with their husbands,

and seven for personal health or family health reasons; the other three nurses left hospitals without official notice.

In recent correspondence, Miss Watt made the following comment:

I would like to assure you that the cordial relationships between our two nursing associations will always remain and we will ever be grateful for the help that the Canadian Nurses Association has given us in recruiting nurses to join the British Civil Nursing Reserve. The members who remain in the Reserve are giving very good service.

History of Nursing Committee

The chairman has worked closely with Mr. Murray Gibbon in the use of the files submitted by the provincial committees on History of Nursing and in securing additional source material as required.

During the past six months, Mr. Gibbon has visited every province except Prince Edward Island and has gathered a great deal of first-hand information, many pictures and human interest stories. It has meant a great deal to the Association that he has established excellent contacts with the French nursing sisterhoods.

Mr. Gibbon has made steady progress in his work of writing the history and it now appears that the manscript will be completed by the autumn. The paper for its printing has been secured and there is every reason to believe that the book will be in your hands before the biennial meeting of 1946.

Interim Report, Editor and Business Manager, The Canadian Nurse

In January, 1945, the Table of Contents and Readers' Guide were moved to the front of the *Journal*. Special pages were initiated for the Postwar Planning Committee and for the Nursing Education Committee in April and May of this year. Monthly guests editorials

prepared by the presidents of the provincial associations also began in May.

During a promotion campaign in the four western provinces, the editor was privileged to address thirty-one audiences regarding the *Journal*. Many new subscriptions were received and contact was made with several prospective authors. The splendid co-operation received from the provincial executive secretaries and *Canadian Nurse* conveners is extremely gratifying.

For the first five months of 1945, 2,168 new subscriptions were received, but during the same period 1,242 subscribers failed to renew. Any suggestions that will assist in the curbing of failure of renewals will be gratefully received.

The Editorial Board approved the purchase of \$2,500 in Victory Bonds in November, 1944, and authorized the purchase of \$3,000 more in the spring drive.

Committee on Placement Bureaux

At the October meeting, the C.N.A. Executive adopted the following motion:

That the appointment of a person to organize and co-ordinate placement bureaux on a national basis be given further study by the general secretary, and that a report be made on this matter at the next Executive meeting.

Miss Gertrude Hall attended a meeting of the Core Committee on April 5. Miss Hall reported rapid development of placement bureaux in the provinces. Discussion emphasized the need for some sort of consultant service being made available to provincial associations. It was agreed that this rapid development indicated the need for some revision of the proposal suggested in the October resolution and the following motion was passed:

It is the opinion of this Committee that present and future needs would best be met by a national consultant rather than a coordinator. If, in the opinion of the C.N.A. Executive, the appointment of such a person on a full-time basis is not possible, the Committee recommends that, for those provinces requiring assistance in the establishment of placement bureaux, consideration be given to the utilization on a part-time basis and in a consultant capacity of some one already experienced in this field.

Committee on Postwar Planning

The activities of the committee on Postwar Planning have been confined to the original objectives, viz: (1) to give assistance in the rehabilitation of nursing sisters; (2) to co-operate with UNRRA; (3) to assist the provincial nurses associations with problems of supplying distribution of nurses; and to encourage promising nurses to prepare for leadership in all fields of nursing.

Replies have been received from the nursing sisters in the R.C.A.M.C. overseas and from all nursing sisters of the R.C.A.F. and R.C.N. (T) to the questionnaires sent out concerning rehabilitation. The information obtained from the questionnaire data has served as a very constructive basis for preparing the type of information which will be of value and interest to those contemplating demobilization. Public health nursing in its various aspects, teaching in schools of nursing, operating room, and surgical nursing are the four major interests of service and education.

It was felt that the most effective means of giving assistance to the nursing sisters on the basis of the information thus received would be through the medium of a personal letter from the president of the Canadian Nurses Association. This letter, which is in the form of a brochure, covers both educational and service plans of the Government and of the C.N.A. in postwar activities. This pamphlet has been prepared in collaboration with the Matrons-in-Chief of the nursing services of the Armed Forces.

UNRRA: On the recommendation of the Executive Committee in October, 1944, a new quota of fifty nurses of all categories for UNRRA was set up by the Association. It is interesting to note that the appointees from Canada have almost all been public health nurses. Our most recent advice from Washington is that they again require only higher-bracket personnel.

Following consultation with Mr. Pearson, Canadian Minister at Washington, we were advised that, should further recruitment of Canadian nurses be requested by UNRRA for service abroad, the salary question should be taken up with UNRRA authorities.

C.C.V.A.: We have been advised by the secretary of the Canadian Council of Voluntary Agencies assisting UNRRA that the activities of this Council are indefinitely suspended.

As a means of giving greater publicity to postwar plans, the committee on Postwar Planning requested a page in *The Canadian Nurse* for all types of information on postwar activities.

General Secretary

This report covers the activities of this Association since the last meeting of the Executive Committee held in October, 1944. Miss Winnifred Cooke arrived at National Office on August 1, 1945, to replace Miss F. Walker, who left on December 15, 1944. Miss Marion Moseley has replaced Miss Henderson, the bookkeeper.

Liaison in Foreign Countries

It was brought to the attention of the Executive that on more than one occasion inaccuracies in interpretation or reporting of Canadian nursing affairs have occurred in the press in other countries. It was suggested that some protective measures should be taken to ensure a more careful interpretation of our affairs in the future; also it would be beneficial to the C.N.A. to be kept informed of significant trends in nursing developments — legal, technical and social — in other countries.

In the light of the above expression of opinion, the following resolution was submitted at the October 27-28, 1944, meeting:

Whereas it is becoming an axiom that if world peace is to be secured there must be international goodwill and understanding not only between nations as such, but also between like groups within these nations; therefore be it resolved that the question be explored of having a Canadian nurse liaison representative in England and in the U.S.A., and other countries when possible, attached to the Royal College of Nursing and the National League of Nursing Education or the American Nurses Association in the same way that the Canadian Government have commissioners.

A letter covering this resolution was written to the executive secretary of the International Council of Nurses on December 12, 1944, and the following reply was received:

I was most interested in the resolution concerning representatives of the Canadian Nurses Association in England and in the U.S.A. I believe that this would be a great step forward towards an understanding between national professional groups. I was particularly pleased as I have lately been thinking on the same lines for the I.C.N.

Survey of Nursing Service Needs as Proposed by Canadian Red Cross Society

In an effort to assist in alleviating present serious shortages of nursing personnel in civilian hospitals in Canada, the Canadian Red Cross Society and the St. John Ambulance Association were approached in August, 1944, by National Selective Service, with a suggestion that the services of nurses' aides, trained under the auspices of these two organizations, should be utilized to a greater extent than at present, in order to dilute available registered nurse per-

sonnel. These aides, heretofore serving in hospitals as volunteers, would under the proposal of National Selective Service be employed on a full-time and salary basis in hospitals requiring their services.

In February, 1945, Dr. F. W. Routley, Commissioner of the Canadian Red Cross Society, Toronto, approached representatives of the Canadian Nurses Association to ascertain whether the latter organization would consent, at the expense of the Canadian Red Cross, to undertake an immediate canvass of the hospital situation throughout Canada in order to determine the following facts: (a) the need of nurses' aides in general hospitals (urban and rural), mental hospitals and sanatoria; (b) the number of nurses' aides requested by each institution desiring such assistance under the terms specified by National Selective Service; (c) the ability and willingness of the hospitals to pay such workers \$60 a month, plus full maintenance and lodging.

On the advice of the president of the Canadian Hospital Council, the general secretary of the Canadian Nurses Association sought the co-operation of Dr. H. Agnew, sceretary of the Canadian Hospital Council, in securing from each provincial hospital association information as to the ability and willingness of the hospitals to pay the suggested sum of \$60 a month, plus maintenance.

Following the approval of the majority of the Executive of the C.N.A., the general secretary of the C.N.A. then commenced a survey of nursing needs in the four western provinces, while the assistant secretary undertook a similar study in the province of Nova Scotia. In addition to carrying out the survey, the general secretary was privileged to attend annual meetings in three provinces, and opportunity was provided in the province of Saskatchewan to meet and address nurses in Regina and Saskatoon.

Forty-two hospitals were visited in three provinces; these included mental hospitals and tuberculosis sanatoria. The total number of nurses' aides required by the hospitals visited in the provinces of British Columbia, Alberta and Manitoba are as follows: 40 in mental hospitals; 45 in general hospitals; 34 in sanatoria; 119 in all.

Treasurer

Monthly financial statements have been prepared for both Canadian Nurses Association and Government Grant funds. These have been submitted to the president, and statements covering C.N.A. funds and the administrative portion of the government grant have been submitted, as is customary, to the honourary treasurer and honourary secretary.

Quarterly financial statements for the periods ended December, 1944, and March, 1945, have been sent to all members of the Executive Committee. The books of the Association were duly audited for the fiscal year ended December 31, 1944.

Total membership reported by the

nine provincial associations as at December 31, 1944 was 21,906, an increase of 475, or about 2.20 per cent.

Government Grant Committee

A letter was read from Dr. G. B. Chisholm, Deputy Minister of Health and Welfare, advising the C.N.A. that five-twelfths of the \$250,000 grant applied for, for 1945-46, had been approved, and that the remaining seventwelfths of the estimated grant would be considered by Parliament following the general election.

The allocation of \$30,000 for bursaries out of the \$104,170 available now, was ratified, as was the policy of continuing to restrict the award of bursaries for short courses, to be taken outside of Canada, to selected applicants. It was agreed that \$20,000 would be allocated for administration in National Office.

The convener of the Bursary Award Committee stressed the necessity for careful selection of bursary applicants by provincial associations. Those applying for bursaries should place their applications through the province where they are presently registered.

Quebec Holds its Silver Jubilee Meeting

The R.N.A.P.Q. celebrated its Silver Jubilee recently, during a meeting which lasted three days, and closed with a banquet. On the Sunday immediately preceding the meeting, hundreds of nurses attended special national memorial and re-dedication services, with groups from all of the nursing services of the armed forces, public health organizations and students representing all schools attending in uniform.

The attendance at all the sessions of the twenty-fifth annual was exceedingly good, especially the one which constituted a "Forum of Current Events as Related to Canadian Nursing". All reports indicated increased activities and demonstrated that

financially our Association is solvent. The main accomplishment of the year was the establishment of District Associations in the twelve areas designated by the Registration Act Amendment passed in 1943. This changes the principle of election to the Committee of Management, which was put into effect for the first time at this meeting. The Committee of Management consists of fourteen members, seven from each language group and elected therefrom in alternate years. Official delegates named by the twelve District Associations cast the vote on their behalf, there being one vote for every one hundred paid-up members in each district. The nomination ticket forwarded

to the District Associations one month before the date of the annual meeting provides the means whereby a secret ballot of all members permits of democratic procedure in such an election.

Business sessions and the Forum were conducted bilingually, other sessions being held separately in French and English, with speakers and topics of their individual choice and interest. Space will not permit me to enlarge upon the reports presented, their reception and the manner in which they were taken to heart, nor to do more than mentions the speakers' names and the topics which they handled with exceptional ability as follows:

Miss Rae Chittick, first vice-president, Canadian Nurses Association, gave us a great deal to think about in her masterly address entitled "Can Nurses Assist in the Return of War Personnel to Civilian Life".

Miss Gertrude M. Hall, general secretary Canadian Nurses Association, provoked much discussion and not a little concern through her excellent and timely presentation of "Two Types of Nurses", many among those present learning for the first time of no less than "six types of nurses" who may share nursing services in a given situation. The papers presented at the Forum precipitated healthy and spirited argument which moved so smoothly one wondered to what extent rehearsals had been conducted. These included "Legislation" by Miss E. C. Flanagan and Miss Ethel Johns; "Labour Relations" by Miss Esther Beith and Mlle Emma Rocque; "Postwar Planning" by Miss Marion Lindeburgh and Mlle Juliette Trudel. Contributing to the discussion were Misses Fanny Munroe, Gertrude Hall, Margaret Kerr, Electa MacLennan, Effie Killins, Margaret Brady, Ann Peverley, Elizabeth Robertson, Rev. Sisters Papineau and Lefebvre, Miles Alice Albert, Maria Beaumier, Marie Cantin, Alice Girard, A. Martineau, A. M. Robert, Emma Rocque and Maria Roy.

Speakers at the French sessions were Dr. Edouard Desjardins, professor of surgery, University of Montreal — "Ce que le public attend de nous" (What the public expects of us); Rev. Père André Guillemette, chairman, Board of Directors, Council of Federation of French-Canadian Charities — "Techniques modernes pour la protection de l'enfance" (Modern technique and method in child care); Dr. Chas. Emile Grignon, chief, Department of Endocrinology, Hôpi-

tal Notre Dame, and professor, University of Montreal — "Les glandes endocrines et la personalité" (Endocrine glands and personality).

At the banquet which brought the Anniversary celebrations to a close, the speakers were Mme Guy Boulizon, professor of education, Stanislas College — "Vues sur les nécessités de l'éducation contemporaine" (Views on the need for contemporaneous education); Dr. H. L. Stewart, professor of philosophy, Dalhousie University, Halifax — "Prospects for the Post-war World". A brief resume of the Association's history to date entitled "Through the Years" was presented by the executive secretary and read in French by Mile Marguerite Taschereau.

At the close of the Forum, during which our legal adviser, Mr. Roger Ouimet, K.C., was present to iron out misunderstandings, two resolutions were presented, discussed and unanimously carried. These were:

Whereas the status of nursing in the Province of Quebec has never been legally established, and whereas it is of public interest that the nursing profession be recognized by law, and whereas Labour laws and Labour codes in Canada and in the Province of Quebec have made no exception for the nursing profession as they have in the case of other professional workers, and whereas rapidly changing world and social conditions make it imperative that nursing be defined as a profession by law, and whereas the public has the right to be protected when dealing with persons whose calling allows them to care for the sick, and whose incompetence would constitute in itself a public menace, therefore be it resolved that the Committee of Management of the Registered Nurses Association of the Province of Quebec be, and they are of these presents fully empowered and urged to proceed with the matter of securing a Nursing Practice Act in the Province of Quebec as soon as possible and practicable.

Whereas the Labour Relations Act of the Province of Quebec contains no provisions excepting Registered Nurses from its application; whereas the nursing profession has not yet been defined by law, and whereas Collective Labour Agreements have been passed by different public and private bodies which have either included some staffs of Registered Nurses or threatened to include same, and whereas it is neither in the interest of the nursing profession nor of the public that bargaining agents on behalf of Registered Nurses be any one but the Registered Nurses Association of the Prov-

ince of Quebec through its authorized representatives, and whereas the provisions of the laws governing similar matters require full authority on the part of the delegating bodies, therefore be it resolved that the Registered Nurses Association through its Committee of Management be and it is hereby empowered to present any and all petitions provided for by law to act as collective bargaining agent for all Registered Nurses of the Province of Quebec whenever Collective Labour Agreements are negotiated with any and all employers of Registered Nurses throughout the Province of Quebec.

Officers elected to the Board for the next two-year period were Misses E. C. Flanagan, Mabel K. Holt, Mary S. Mathewson, Ethel B. Cooke, Rev. Sister Flavian (all reelected) Misses Vera Graham and Ann Peverley, following which, according to regulations, the entire board met and elected from their number the following officers: president, E. C. Flanagan; French vice-president, Rev. Soeur Valerie de la Sagesse; English vice-president, Mary Mathewson (all re-elected); honourary secretary, Ethel B. Cooke; honourary treasurer, A. Martineau.

The principle of pensions for permanent employees at Association headquarters was adopted by the Committee of Management in honour of the occasion. An annuity plan to which both employer and employee will contribute is being worked out and will go into effect immediately.

E. Frances Upton
Executive Secretary and Registrar,
R.N.A.P.Q.

Annual Meeting in Nova Scotia

The thirty-sixth annual meeting of the Registered Nurses Association of Nova Scotia was held at the First Presbyterian Church, New Glasgow, on June 13 and 14, 1945, with the president, Miss Rhoda MacDonald, in the chair. The Association was entertained by the Pictou County Branch, R.N.A.N.S.

The meeting opened with an inspiring invocation by the Rev. Lloyd MacLennan of the First Presbyterian Church, followed by an address by Mayor MacLeod of New Glasgow. He welcomed the members to the town, emphasizing the fact that the war is not yet won, and that the nurses still have an important part to play. Miss MacDonald then welcomed Miss Gertrude Hall, general secretary, C.N.A., and Miss Margaret Kerr, editor of The Canadian Nurse, to the meetings. Miss MacDonald, in her opening remarks, stressed the need for co-operation on the part of each and every member if the Association is to progress.

The reports of the registrar-treasurer-corresponding secretary were presented. The financial balance was satisfactory. The paid-up membership showed an increase of sixty-nine members over that of the previous year. Temporary reciprocal registration has been granted to fifteen active members of

other associations, and two special permits have been granted to graduate nurses who are not registered.

A number of surveys have been made during the year, and a summary regarding student and graduate staff of hospitals has been sent to National Selective Service. Many letters and posters for recruitment have been distributed, and a great deal of publicity has been handled through the provincial office. The Nurses Placement Bureau is functioning, but due to the shortage of nurses has made only a few placements.

The registrar gave a brief account of the registrars conference held in Montreal on June 4 and 5, 1945, bringing out points regarding reciprocal registration with other provinces. A committee was then formed, with Miss Jean Forbes as convener, to study the application forms for registration in this province, and to make necessary changes in order to have more data regarding each applicant on file in the office.

Seven of the eight Branches of the Association were represented, and interesting reports of their activities for the past year were given.

The General Nursing Section recommended that a refresher course be given later in the year for that Section, to be financed by Government Grant funds. They also suggested that eight-hour duty be enforced in those localities where there is no shortage of nurses. Both these recommendations were approved.

On the recommendation of the Hospital and School of Nursing Section, a committee was formed, with Miss Lillian Grady as convener, to study the first year qualifying examinations with a view to establishing them in Nova Scotia, beginning with the January, 1946, class.

The request of the Public Health Section to study the possibilities of holding a Job Instruction Training institute, to be financed by refresher course funds, was granted. This Section reported having held a refresher course during the past year, conducted by Miss Mary Mathewson, assistant director, McGill School for Graduate Nurses. The Library Committee purchased seven books during the year.

Miss Gertrude Hall spoke on the need of an active Legislative Committee, in order to carefully observe provincial legislation, and to study the changes in the C.N.A. constitution which will be reported by the National Committee. Miss Rhoda MacDonald gave an excellent report as councillor to the C.N.A. executive meeting. Miss Lenore Mac-Millan gave a comprehensive report on hours of duty and rates of pay throughout the hospitals in Nova Scotia.

The afternoon session opened with an address by Miss Gertrude Hall on "Two Types of Nurses", who, in a clear concise way, explained the differences in the training of these types of nurses, clarifying many important points in the minds of those present. Miss Margaret Kerr brought greetings from Miss F. Munroe, president, C.N.A., to the meeting. In her talk she stressed the need for more articles and subscriptions for the Journal.

In connection with the report of the Postwar Planning Committee, it was decided to form a special committee to welcome the returning nursing sisters, with Miss Archard as convener. Miss Rhoda MacDonald gave a report of the Labour Relations Committee. in which she stated that the lawyer had notified the committee that, in Nova Scotia. nursing was legally considered a profession. The committee was then given permission to investigate the Workman's Compensation Act in relation to nurses. The meeting also decided to engage a lawyer for the Association on a retaining basis.

It was duly carried that the registrar and president be sent to all C.N.A. executive meetings, the registrar to the annual registrars conference, and the registrar and president to the next biennial meeting, with all expenses paid.

It was brought to the attention of the meeting the benefits each might receive through an affiliation with the Provincial Council of Women, and it was decided to make a request for this affiliation. A recommendation, "that a committee to study the advisability and possibility of university post-graduate courses for nurses in public health, and teaching and supervision, to be established in Halifax in conjunction with Dalhousie, be formed", was approved with Miss Lenta Hall as convener.

The following officers were elected: president, Rhoda MacDonald, Sydney; first vice-president, Lillian Grady, Halifax: second vice-president, Lenta Hall, Bedford; third vice-president, Gladys Strum, Halifax; recording secretary, Frances MacDonald. Halifax; section chairmen: Hospital and School of Nursing, Sr. Catherine Gerard, Halifax; Public Health, Margaret Ross, Pictou; General Nursing, Mabel MacPhail, Sydney; committee conveners: program & publication, Mrs. C. Bennett, Halifax; legislative, Marion Haliburton, Halifax: nominating, Betty Duff, Stellarton; library, Sr. Mary of Calvary, Antigonish; arrangements, Mrs. Bertie Sanford, Amherst; adviser to registrar, Sadie Archard, Halifax.

Several delightful social events brought the meeting to a successful close.

> JEAN C. DUNNING Registrar, R.N.A.N.S.

When the S.R.N.A. Met in Prince Albert

Nurses from sixteen centres in the province met in Prince Albert on June 14 meeting of the Saskatchewan Registered

and 15, 1945, when the twenty-eighth annual

Nurses Association was held. For the third time, the Association was privileged to have convention headquarters at the Sanatorium where every facility was placed at their disposal. The personal interest of Dr. and Mrs. R. W. Kirkby and Mrs. M. Stephen, and of the staff at the Sanatorium, was reflected everywhere.

For the first time in the history of the Association, at least one student from each school attended the meeting. A special session for student nurses was held the first day under the guidance of Miss E. Worobetz when "The Students' Responsibility for the Social Life of the School" was discussed.

Following the invocation, and the address of welcome given by His Worship Mayor G. E. Brock, to which Mrs. G. Droppo, president of the Moose Jaw Chapter, responded, the morning session was devoted to business when reports were presented. These were mimeographed and a copy given to each delegate, the highlights only being discussed by those responsible for them. It is hoped that the folios will serve as useful references during the coming year.

Miss M. Diederichs presided at all sessions. As a result of her recent contacts with the Executive Committee of the Canadian Nurses Association, Miss Diederichs was able to bring much that was of special interest to the delegates. In her inspiring address she spoke of the need for new solutions to meet new problems in a changing world and appealed for the active participation of every nurse in meeting these.

Business sessions of the three Sections were held on the first afternoon, followed by a discussion on "Our Profession, Today and Tomorrow" lead by Misses M. Chisholm, E. Smith and E. James, representing the three Sections. A marionette show, demonstrating play therapy and a possibility for a publicity program, was given by high school students under the direction of Mrs. R. A. Spencer, Saskatoon, as the concluding event of the afternoon.

The second day of the convention Mr. F. A. McKinnon, Staff City Park Collegiate, spoke on "How Well Do You 'Rub Elbows'". This was followed by an address given by Mrs. Elda Cameron entitled "Nurses as Citizens". Out of these very stimulating addresses discussions took place on the value of a health teacher in a school of nursing, whose functions would be enlarged to include care and direction of the entire

health, recreational and social program in a school; also the teaching of public health to students from the time of their entry into the school. The value of a sports and recreational program in which individual nurses, rather than picked teams, would participate as a matter of choice was also stressed. The exhibit on display was referred to as including handicrafts which nurses might well develop.

A lively presentation of "Nursing Needs a Press Agent" was given by Mr. E. Parker, Promotional Director of Adult Education in Saskatchewan. This was ably supported by Miss Grace Giles who spoke on "The Nurse as a Press Agent". Misses Lorena McColl, Mary Bohl and Mrs. Verna McCrory gave a delightful presentation of *The Canadian Nurse* as a professional ally.

At the closing session a special resolution of appreciation was recorded to Miss M. Diederichs who retired from the office after four years during which she has served the Association and profession untiringly. In this resolution Miss Diederich's contributions were referred to as very special ones, the lasting effects of which would be reflected in many future developments of the Association and profession. On behalf of the Association Mrs. D. Harrison, the newly-elected president, presented Miss Diederichs with a compact and scroll on which the resolution of appreciation was inscribed.

The following officers were elected: president, Mrs. Dorothy (Cotton) Harrison, Saskatoon; first vice-president, E. Pearston, Fort Qu'Appelle; second vice-president, M. E. Pierce, Regina; councillors: Rev. Sr. Irene, Prince Albert; M. E. Thompson, Regina; section chairmen: General Nursing, Mrs. Verna McCrory, Prince Albert; Hospital and School of Nursing, Alice Ralph, Moose Jaw; Public Health, E. Smith, Regina.

The preparations made for the meetings by the Prince Albert Chapter, under the leadership of the president, Mrs. Verna McCrory, and Mrs. G. Josephine Zakus, secretary, were in keeping with the record already set by nurses in this hospitable centre. Both graduate nurses and students left with a feeling of warm appreciation and look forward to a reunion in Moose Jaw in 1946.

K. W. ELLIS
Registrar, S.R.N.A.

Postwar Planning Activities

Contributed by

POSTWAR PLANNING COMMITTEE OF THE CANADIAN NURSES ASSOCIATION

Opportunities in D. V. A. Hospitals

Postwar planning for nurses and nursing services is now becoming more realistic in many respects. The brochure of information for demobilized nursing sisters, prepared by the Postwar Planning Committee, is now in circulation and can be secured from all provincial nurses associations. We are glad to know, through letters received by our president; that the information contained its serving its purpose in assisting nursing sisters to re-establish themselves following demobilization.

It is gratifying to know that so many returned nursing sisters are taking advantage of the financial aid provided by the Federal Government for educational purposes and are enroling in university schools across Canada. In many ways they will be better prepared to meet the great challenge of nursing services that exists throughout the country.

Facilities in mental and tuberculosis hospitals, particularly, are being rapidly expanded to meet an urgent need, and provision for hospitalization and rehabilitation of veterans is well underway. Personnel and nursing needs in these hospitals, administered by the Department of Veterans Affairs, are very important considerations.

Miss Agnes J. Macleod, newly appointed Matron-in-Chief for Director General of Treatment Services, Department of Veterans Affairs, wishes to bring to the attention of the nursing public, and particularly to nurses returning from overseas, the need for nurses in Veterans Affairs hospitals.

In the near future a nursing bulletin will be issued by the Department of Veterans Affairs bringing to nurses information regarding the special phases of medical treatment work. Until such information is available nurses, who are interested in applying for positions in hospitals under the Department of Veterans Affairs, should note the following points:

All appointments are made by the Civil Service Commission; application forms in English or French are obtainable in local post offices of larger towns and cities, district offices of Civil Service Commission, or in Ottawa, and in all Department of Veterans Affairs offices. Applications are sent in duplicate to the District Civil Service Commission. The Civil Service Commission reviews applications and keeps a list of eligible nurses for vacancies in particular districts.

Information as to classification for grading, including duties, qualifications and salaries, will be shown in detail in the forthcoming bulletin, as well as reference to extra allowances, csot of living bonus, uniform allowance, vacation, hours of duty, and other points of interest.

The year ahead will be one of rapid change and adjustments in all fields of nursing. Provincial nurses associations will carry increasing responsibility in their attempt to supply qualified nurses for administrative and supervisory positions, in meeting the increasing needs for adequate nursing in hospitals and in the public health nursing fields.

Nursing Education

Contributed by

COMMITTEE ON NURSING EDUCATION OF THE CANADIAN NURSES ASS'N.

The Accreditation of Schools of Nursing

At the meeting of the Executive Committee of the Canadian Nurses Association in Montreal at the end of May, following the discussion of recommendations from two provinces, this motion was passed:

That the Canadian Nurses Association approve the principle of accreditation for schools of nursing in Canada, and that the Committee on Nursing Education be asked to initiate a plan of action as quickly as possible.

The dictionary defines "accredit" as "to vouch for; to furnish with credentials"; and accreditation as "the action of accrediting or being accredited; authoritatively sanctioned". This sanctioning could result either from meeting a legal requirement; or it could be voluntarily sought by a school which endeavoured to meet certain professional standards.

It will be noted that our nursing schools have a certain amount of statutory accreditation through the inspection which is carried on provincially. This, however, merely checks on absolutely minimum standards and we know that there is still great variation

in the standards of schools within each province.

The accreditation which is being discussed now by the Canadian Nurses Association is for all Canada, and its object is to raise the standard of nursing service throughout the country. The purposes of such a program have been defined by American authorities to include the stimulation of the improvement of nursing education by defining desirable standards for nursing schools; the encouragement of those responsible for nursing schools to meet these standards: assisting prospective nursing students in selecting nursing schools; obtaining information which will be useful in educating professional and lay groups regarding nursing education.

Schools would apply voluntarily to be accredited against certain broad definite standards which would cover all aspects of the school. Thus accreditation would consider not only details of the curriculum, but such matters as the organization and administration of the school; the school building; teaching facilities; teaching staff; students; living and working conditions for students; the curriculum.

The Education Committee hopes to present a plan for accreditation to the Executive Committee this autumn.

An Omission

Due to an oversight, the certificate course in public health nursing at the University of Montreal was omitted from the list which appeared on the Nursing Education Page in the July 1945 issue of the *Journal*. This course for the French-speaking nurses covers one academic year. We regret that no mention was made of this course.

Interesting People

Agnes Jean Macleod, R.R.C., has recently returned from overseas service with the R.C.A.M.C. to become the matron-in-chief with the Department of Veterans Affairs. She will be responsible for the nursing service in all of the hospitals and treatment institutions sponsored by the Department.

After graduating from the University of Alberta with her B.A. and B.Sc., Miss Macleod put her normal school training to good effect by acting as instructor in two Alberta schools of nursing. In 1932, she received her M.A. from Teachers College, Columbia University, and spent the next five years in the teaching department at the Vancouver General Hospital. At the time of her enlistment in the R.C.A.M.C. in 1940, Miss Macleod was director of the School of Nursing in the University of Alberta.

As principal matron, Miss Macleod saw service in Sicily, where she was wounded, in Italy and later in France and Belgium. Miss Macleod was awarded



AGNES J. MACLEOD

the Royal Red Cross for meritorious service.

Prior to going overseas Miss Macleod was very active in provincial and national nursing association work. She was chairman of the national nursing education section at the time of her enlistment, and also chairman of the committee on nursing of the Canadian Hospital Council.

Lucile Petry, Director of the Division of Nurse Education, United States Public Health Service, recently received honourary degrees from Adelphi College, Garden City, New York, and the University of Syracuse, New York.

The degree of Doctor of Humane Letters was conferred upon Miss Petry by Adelphi College on June 6. At the ceremony dedicating the new school of nursing building at Syracuse University on June 7 Miss Petry was awarded the degree of Doctor of Laws.

Miss Petry is a graduate with honours of the University of Delaware, of Teachers College, Columbia University, and of the Johns Hopkins Hospital School of Nursing. In July, 1943, she became the first woman director of a division of the United States Public Health Service, and leader of the largest uniformed women's organization in the United States, the U. S. Cadet Nurse Corps.

In presenting the honourary degree of Doctor of Laws, Chancellor William P. Tolley, of the University of Syracuse, cited her for her "work on programs of far-reaching significance for the health of the Nation, striving always with courage and clear vision born of a dauntless belief in the social importance of the nurse . . . and labouring to bring about the highest standard in the care of the sick, in public health and in nursing education".

Maude H. Hall, assistant superintendent, Victorian Order of Nurses for Can-



Underwood & Underwood, Washington
LUCILE PETRY

ada, was recently awarded a Rockefeller travelling grant and spent several weeks visiting various public health and visiting nursing organizations in the United States.

Born and educated in Ontario, Miss Hall is a graduate of the Johns Hopkins Hospital School of Nursing and took post-graduate training in public health nursing at the University of Toronto and at Teachers College, Columbia University.

Miss Hall has had an interesting and varied career in nursing both in this country and the United States. During the first world war, she served in France as a nursing sister with Base Hospital No. 18, the Johns Hopkins Unit. After the war, she worked with the Massachusetts Halifax Health Commission and then with the Toronto Department of Health for two years. Following this, Miss Hall was appointed supervisor of the Instructive Visiting Nurse Society in Washington, D.C., and then became director of the Visiting Nurse Association of Holyoke, Mass. In 1928 she joined the staff of the Public Health Clinic of Dalhousie University. In 1930 she became assistant superintendent of the Victorian Order of Nurses for Canada. During the four years that Miss Smellie was Matron-in-Chief of the R.C.A. M.C. Nursing Service, Miss Hall served



MAUDE H. HALL

as chief superintendent of the Victorian Order of Nurses.

Because of the extensive student affiliation program of the Victorian Order, one of Miss Hall's chief interests during this observation period was student affiliations for both graduate and undergraduate nurses. Her travels took her to Detroit, Battle Creek and Lansing in Michigan; to New York City; to Hartford, Conn., and to Boston, Mass.

Lillian J. Johnston has been appointed chief nurse, Health Division of UNRRA. Since March, 1944, Miss Johnston has been serving as acting chief nurse. As



UNRRA Photo

LILLIAN J. JOHNSTON

chief nurse she will maintain contact between UNRRA and other organizations concerned with nursing on an international scale, such as the Rockefeller Foundation, International Council of Nurses and the Nightingale International Foundation. Miss Johnston will be responsible for the qualification standards to be used in the recruitment of all American and Canadian nurses for UNRRA. She will work also in conjunction with the European Regional Office to secure competent French and other native European nurses to help in UNRRA's nursing program.

Miss Johnston graduated from the Hartford Training School for Nurses and Teachers College, Columbia University. Before her appointment to the UNRRA office she was a Senior Public Health Nurse with the Office of Foreign Relief and Rehabilitation Operations, a subdivision of the State Department instrumental in setting up UNRRA's initial organization. Previously she worked in the Public Health Service in New York as consultant to the Office of Civilian Defense to promote plans for nurses to take part in the Emergency Medical Service in New York, New Jersey and Delaware. She was county supervising nurse in the Westchester County Health Department, in White Plains, New York, and a staff nurse at the Springfield Visiting Nurse Association in Springfield, Mass.



MATILDA R. DIEDERICHS

The many friends of Lyle M. Creelman will be interested to know that she has recently assumed the duties of chief nurse, Health Division, UNRRA in charge of the work in Germany. Miss Creelman has been associated with the London office of UNRRA for the past few months. Prior to proceeding overseas, Miss Creelman was director of the nursing service with the Metropolitan Health Committee in Vancouver.

Matilda Rose Diederichs, who has been instructor of nurses at the Regina Grey Nuns' Hospital for the past nine years, has accepted a similar position with St. Joseph's Hospital, Victoria, B.C., instructing in the science subjects. A graduate of St. Paul's Hospital, Vancouver, Miss Diederichs received her certificate in teaching and supervision in schools of nursing from the McGill School for Graduate Nurses. In addition, she has taken courses in x-ray technique and physiotherapy with the Victor Corporation in Chicago.

Miss Diederichs has made an outstanding contribution to nursing during her years in Saskatchewan. She served in various capacities in both local and provincial association work, notably as president of the S.R.N.A. from 1941-45. Her broad understanding of nursing needs and her ready willingness to assist wherever possible have proved a strength during these difficult war years. We wish her well in her new endeavours,

Dorothea Shields, having completed a period of observation and study with the Kellogg Foundation in Michigan on a scholarship, has returned to the Metropolitan Health Committee Service in Vancouver as consultant in communicable disease control.

Miss Shields, a native of Ontario, graduated from the Winnipeg General Hospital and received her public health certificate from the University of British Columbia. After two years of specialling, she joined the nursing staff of

the Vancouver School Board. When the amalgamation of the health services in the metropolitan area of Vancouver took place Miss Shields continued as a staff nurse until 1942 when she became one of the Unit supervisors.

Charlotte Graham Crowe has undertaken an exceedingly interesting piece of work as instructor in the new affiliation course for student nurses organized by the Saskatchewan Anti-Tuberculosis League. Graduating from the Regina General Hospital, Miss Crowe served for a year as resident nurse at Regina College. After she received postgraduate training in tuberculosis, she was placed in charge of the orthopedic ward at Fort Qu'Appelle Sanatorium. For the past three years she served as supervisor of the operating room at that sanatorium. Miss Crowe broadened her qualifications for this interesting new work by recently taking the course in teaching and supervision at the University of Manitoba.

Miss Crowe believes in having an absorbing hobby. She is interested in petit point designing and needlework.

After nearly a quarter of a century of faithful service as public health nurse in Welland, Ontario, Anna Mary Oram has retired from active work. Born in Ontario of Scottish-English parentage, Miss Oram graduated from the Toronto General Hospital in 1913. From 1915-19, during the first world war, she served as a nursing sister with No. 4 Canadian General Hospital, University of Toronto Unit, in France, Dardanelles, Malta, Salonika and Canada. On her return to civilian nursing Miss Oram joined the first class in public health nursing given at the University of Toronto. Her assignment to infant welfare work in Welland followed graduation. Upon her retirement, numerous presentations were made to Miss Oram, the most interesting of which was a tribute from the mothers of Welland whom she had assisted so ably throughout the years, a gift of enough Victory Bonds to go a long way towards the purchase of a car when they are available.

Miss Oram has always been very active in nursing association work. At present



Davidsons, Wianipe a
CHARLOTTE G. CROWE

she is second vice-chairman of District 4, R.N.A.O., and also councillor for the Niagara section of this district. With release from her official duties, Miss Oram will have more time to devote to her beloved books and her friends, her flowers and her home. We wish her joy in her retirement.

Hannah Elizabeth Smith, who has served with the Ontario Department of Health for twenty-five years, retired at the end of June. A native of Halton County, Ontario, Miss Smith graduated



ANNA M. ORAM



H. ELIZABETH SMITH

from the Roosevelt Hospital, New York City, in 1917. A year of institutional work preceded her entry into the publice health field where her activity commenced with the Health Department of Toronto. The following year, Miss Smith transferred to the Ontario Red Cross Society and organized a generalized program in the Danforth area. Her activity following her appointment to the Ontario Department of Health was to pioneer in the development of public health nursing services in isolated communities. In 1925, her work took her to the Township of Teck, which included Kirkland Lake. It is a tribute to her organizing ability that today, twenty years later, a full-time health unit with five public health nurses flourishes in

this area. Nine months after her introduction to Northern Ontario, Miss Smith moved to New Liskeard where her territory covered an immense area. She averaged seven thousands miles of travel by motor during the summer months.

Despite her busy program, Miss Smith found time for nursing association work. She was chairman of District 9, R.N.A.O., for six years and played a prominent role in stimulating the formation of chapters in seven centres.

Retiring now to her home in Oakville, Miss Smith will have time to indulge in her greatest delight, working in her garden. Her many friends join in a sincere wish that she may long enjoy the rich contentment to which her years of activity entitle her.

At its annual meeting this year, the Saskatchewan Registered Nurses Association decided to make provision for honourary members to include all nurses who, having served long and faithfully, are retiring from professional activity after having been members for twenty years or more, and also charter members whose names appear in the act of incorporation. The following nurses were named as honourary members at this time: Jean Browne, Jean Wilson, Effie Feeny, Ruth Hicks, Ellen Love, Ruby Simpson, Helen Walker, Elizabeth Van Valkenburg, Norah Armstrong. Madge Berry, Margaret McGill, and Catherine Isabel Stewart. To each of these we offer our sincere congratulations.

Obituaries

On June 11, 1945, at "Hope", 17 St. Paul's Road, Paignton, England, Emily Cooper, aged 88, passed peacefully away. A graduate of the Montreal General Hospital, Class of 1892, Miss Cooper was the first graduate nurse to be appointed superintendent of nurses at the Montreal Maternity (1892-1896). She and her sister, Miss Emma, a graduate of the Royal Victoria Hospital, studied massage in

Philadelphia and returned to Montreal where they practised their profession until 1909 when they returned to England.

Mrs. Elisabeth Masse, a graduate of the School of Nursing of the Notre Dame Hospital, Montreal, died recently after a lengthy illness. Mrs. Masse was with the Mount Royal Nursing Staff (Montreal) of the Metropolitan Life Insurance Company Nursing Service for over twenty-four years.

Vera MacDonald, a graduate of the Halifax Infirmary, Halifax, N. S., Class of 1942, who joined the No. 4 Canadian General Hospital Unit in January, 1944 and went overseas in June of that year, was fatally injured in a car accident while on a pleasure trip in Fran-

borough, England. Miss MacDonald was a graduate of St. Anne's high school Glace Bay, N.S. She was president of her class at the hospital, was bright, vivacious and a general favorite with both nurses and patients.

M. Edna Baird, of Woodstock, Ontario, died recently. She was graduate of the School of Nursing of the Royal Victoria Hospital, Montreal.

Ontario Public Health Nursing Service

Mrs. Marion (Granger) Greenwood (Vancouver General Hospital and University of British Columbia) has accepted an appointment with the Swansea Board of Health.

Helen Gardner (St. Luke's Hospital, New York City, and University of Toronto public health course) has accepted the appointment of senior nurse in the Huron County School Health Service.

Mrs. Susannah Childerhose (Connaught Training School for Nurses, Weston, and University of Western Ontario public health course) has been appointed senior public health nurse at Woodstock.

Mrs. H. D. (Jackson) Rice (Toronto General Hospital and University of Toronto public health course) has resigned her position with the Woodstock Board of Health.

Rita Sutcliffe (Hospital for Sick Children, Toronto, and McGill University public health course) has resigned her position at Swansea to accept the appointment of senior nurse in the Halton County School Health Service.

Marion Thompson (Toronto General Hospital and University of Toronto public health course) has resigned her position with the Peel County School Health Unit to accept an appointment with the Windsor Department of Health.

Helen Larkin (New York Hospital and University of Toronto public health course) has resigned her position at Kenora to accept the appointment of public health nurse at Parry Sound.

Isabel Pringle (Guelph General Hospital and University of Western Ontario) who has recently returned from overseas service with the R.C.A.M.C., has accepted an ap-

pointment with the Windsor Department of Health.

Bessie Skinner (Toronto General Hospital and University of Toronto public health course) has resigned her position with the Guelph Board of Health to accept the appointment of public health nurse at Simcoe.

Mrs. Mary MacPherson (Johns Hopkins School for Nurses, Baltimore, and summer course in school nursing) has accepted an appointment with the Owen Sound Board of Education.

Hilda Vohman (Grace Hospital, Toronto, and University of Toronto public health course) has resigned her position as public health nurse at Ajax to accept an appointment with the Lincoln County Health Unit.

Louise Steele (Memorial Hospital, Worcester, Mass., and Western Reserve University, Cleveland, public health course) has accepted the position of supervisor with the Durham and Northumberland County Health Unit.

The following graduates of the public health nursing course at the University of Toronto have accepted appointments: Anne Gibson (Toronto General Hospital) with the Halton County School Health Service; Edna Hulse (Women's College Hospital) with the Division of Epidemiology, Province of Ontario Department of Health; Eileen Morris (St. Michael's Hospital, Toronto) with the Oshawa Department of Health; Mrs. Mary Black Fraser (University of Iowa School of Nursing) with the Division of Epidemiology, Ontario Department of Health; Eleanore Mason (Hamilton General Hospital) with the United Counties Health Unit.

The following graduates of the public

health nursing course at the University of Western Ontario have accepted appointments: Joyce Hankinson (Brantford General Hospital) with the Brantford Board of Health; Janet McDonald (Victoria Hospital, London) with the Lincoln County Health Unit;

Dorothy Stone (Brantford General Hospital) with the Oshawa Board of Health.

Mildred Haberer (Stratford General Hospital) and Jean Falconer (Kitchener-Waterloo Hospital) with the Huron County School Health Service.

P.E.I. Registered Nurses Meet

The annual meeting of the Prince Edward Island Registered Nurses Association was held in May and it was our good fortune to have as a guest, Miss Electa MacLennan, from National Office. After the presentation of some reports, Miss MacLennan explained them more fully and helped broaden the picture for us. She spoke also on some national problems. Other speakers included Dr. Wendell MacDonald who spoke on "X-Ray Therapy" and Mr. Lloyd Shaw who gave an interesting discourse on "General Education in Prince Edward Island".

Previous to the meeting the sections met concurrently and discussed the problems relevant to each. An enjoyable supper was served by the Ladies Aid of Zion Church.

The following officers were elected: president, Dorothy Cox; vice-president, Mildred Thompson; secretary, Helen Arsenault; registrar-treasurer, Sr. M. Magdalene; section chairmen: Hospital and School of Nursing, Sr. M. Irene; General Nursing, Mary Lannigan; Public Health, Sophie Newson.

We are looking forward to the time when the nursing sisters will be returning to our provincial association to continue the advance of our work.

> HELEN ARSENAULT Secretary, P. E. I. R. N. A.

Scholarships in Public Health Nursing

The Quebec Provincial Division of the Canadian Red Cross Society offers scholarships, of the value of \$500 each, to nurses, who are graduates of approved schools of nursing, in order that they may pursue the course of one year in Public Health Nursing at any one of the schools for graduate nurses conducted under the auspices of the Universities of the Province of Quebec. Essential Qualifications:

- 1. The candidate must produce a letter from the director of the school for graduate nurses stating that she has met all the requirements of the University for admission to the course in public health nursing.
- 2. She must possess a strong physique and good health.
- 3. She must give proof of personal aptitude for community service.
- 4. She must furnish a certificate of University matriculation or provincial high school leaving certificate (Grade XI) with an average of 60 per cent.
 - 5. She must be willing to sign a contract

to serve in a Red Cross Nursing Outpost or in a public health nursing field designated by the Red Cross for a period of two years immediately following graduation from the University.

Desirable Qualifications:

1. Previous nursing experience under supervision.

2. Bilingualism.

For further information address: The Commissioner, Canadian Red Cross Society, Quebec Provincial Division, 3416 McTavish St., Montreal 2.

Preview

Complementing the discussion of the relationship between the hospital and the public health department which was opened in our July issue, Miss Violet Carroll will describe the operation of the hospital health service plan in Toronto in our next issue.

STUDENT NURSES PAGE

Abdominal Perineal Resection

JOYCE WALKER

Student Nurse

School of Nursing, Victoria General Hospital, Halifax.

Mrs. A. entered hospital August 3, 1944. She was a tall, rather stout, palefaced woman, sixty-three years of age. She was not unduly nervous about entering the hospital as her daughter, who is a nurse, had prepared her for much of the investigation and treatment and had accompanied her to the city. She was born and had lived all her life in a little village. She had always been fairly well, had had no operations and only one serious illness, infantile paralysis, when a young child, which had left her right arm paralyzed. Apparently this did not handicap her greatly as she had borne and raised eleven children.

Her complaints were the following: passing blood and mucus per rectum; discomfort and pain from abdominal gas. For many years she had suffered from constipation which required the constant use of laxatives. In the past two years she experienced a feeling of fullness in the rectum and on efforts to defecate only passed gas and mucus which did not relieve the desire to defecate. In April, 1944, she noted blood in the stool and throughout the early summer blood was seen in small quantities. On July 17, 1944, she had a severe hemorrhage and was greatly alarmed. She consulted a doctor who recommended hospitalization for observation. There was no further bleeding up to the time of admission to hospital.

Her history was essentially negative, the only history of cancer in her family being a maternal uncle. In the physical examination nothing in the way of abnormal findings were obtained. Her blood pressure was high, systolic 190 and diastolic 100. There was nothing abnormal found in the urine and the blood counts were favourable. The rectal examination revealed a dense constricting band surrounding the rectum, which bled readily on being touched.

On August 8, 1944, a colostomy was performed. A blood transfusion was given and the patient's condition was good. On August 12 the colostomy was opened by cautery and considerable flatus was expelled which afforded Mrs. A. relief. Colostomy irrigations (saline) were begun on August 14, and were given daily thereafter. She was advised what foods to eat to avoid frequent defecation and also how much fluid to take. Constipation was troublesome at first but her bowels soon moved well with irrigations.

On September 12, the second operation, abdominal perineal resection, was performed. A midline incision and a perineal incision were made in order to free and remove the whole lower rectum. The perineal incision was packed with gauze and the midline incision was sealed with a collodion dressing. She received 1500 cc. citrated blood on

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return to the ward. The perineal packing was gradually removed over a period of several days. When the packing was all removed the wound was irrigated twice a day with normal saline through a catheter inserted in the sinuses. There was considerable purulent drainage for sometime from two sinuses. Later the irrigation solution was changed to half strength Dakin's. The colostomy was irrigated daily with saline. The midline incision healed well with no signs of infection. About three weeks after the operation the patient received hot sitz baths. The sinuses gradually healed and the irrigations and baths were then discontinued.

Mrs. A. was unable to void for twenty-two days following her operation. It was necessary to catheterize her q6h. Hot compresses to vulva, prostigmine, and other methods were used to induce voiding but to no avail. The bladder was irrigated daily with potassium permanganate 1:8000 solution and argyrol 5 per cent instilled. Sulfathiazole was given to prevent cystitis.

Ferrous sulphate grs. III was given once a day and a high vitamin, high caloric diet. The patient made an excellent recovery and left the hospital undaunted by the fact that she had a permanent colostomy which was probably because she knew her daughter was going to take care of her and none of the responsibility for the irrigation and dressing need fall on her.

Royal Alexandra Nurses Choral Club

L. OLYNYK

One of the most interesting and popular extra-curricular activities carried on in the school of nursing at the Royal Alexandra Hospital, Edmonton, Alberta, is the Nurses Choral Club. For nearly eight years now, student nurses numbering from thirty to fifty have gathered together once weekly in the reception room of the nurses home to spend the evening in song.

Although few of the members possess outstanding talents as singers, under the excellent guidance of their leader, Mr. G. A. Kevan, F.T.C.L., A.C.C.O., the Choral Club has built up a widespread reputation for its pleasing quality of tone. This task has not been easy because of the constant changing of the members as they progress through their training.

The original purpose of the organization was to provide fun and fellowship for its members; however, many people outside of the Club have received pleasure as well. In our own hospital each Christmas morning both patients and staff have been cheered by the strains of Christmas carols sung by the group. A concert for the tuberculosis patients is another annual event.

Several radio broadcasts have been given during each season and these have been very favourably received by the public. Singing at the graduation exercises, at a nurses re-dedication service, and at Robertson United Church are other highlights of the year. The club has also had the pleasure of singing at the provincial I.O.D.E. convention, and last year at the national convention of the I.O.D.E. In the provincial musical festival the Choral Club has won warm praise with its adjudication and, in 1941, the T. Eaton Shield was brought to the Royal Alexandra Hospital.

What is Acid-Moisture ?



Dermatitis in infants brought about by wet diapers, clothes and bed clothes is a common and troublesome condition. Because of it the busy physician is often faced with questions from anxious mothers. While normally acid because of uric acid content (C₆H₄N₄O₃), urine is sometimes converted into an alkaline irritant in the "ammoniacal diaper" by urea-formed ammonia (NH₃).

On the basis of simple mechanical protection, the use of Z.B.T. Baby Powder

with olive oil helps to resist moisture dermatitis. Z.B.T. clings and covers like a protective film—lessens friction and chafing of wet diapers and shirts. The mechanical moisture-resisting property of Z.B.T. may be clearly demonstrated. Smooth Z.B.T. on the back of your hand. Sprinkle with water or other liquid of higher or lower pH. Notice how Z.B.T. Baby Powder keeps skin dry as the drops roll off. Compare with any other baby powder.

Z.B.T.—the only baby powder made with olive oil

SEPTEMBER, 1945 731



McDermid Studios, Edmonton

Miss Margaret S. Fraser, superintendentof nurses, and Mr. G. A. Kevan, the director, are shown with the choir.

An outstanding item in the history All in all, the Choral Club has been of this group was the purchase of a portable organ to be used in the hospital. Financially, the Club has done well, and has been able to contribute to the Red Cross.

a great success, and we are looking forward to greater accomplishments in the future. We also hope to see the appearance of Choral Clubs in many other hospital schools of nursing.

Letters to the Editor

UNRRA Girls Live the Hard Way

At Lamia in Greece a small group of people are doing a job of work of which very little or nothing has been told. One of them is Miss Heather Kilpatrick, UNRRA regional nursing consultant from Vancouver, Canada. Miss Kilpatrick is a graduate of the University of British Columbia, of the Vancouver General Hospital, and was director of Public Health Nursing of the Provincial Board of Health in Victoria, Canada. And another is Miss Ruth D. Ballam, American public health nurse, who has acted as a nursing field representative for the American Red Cross in Tennessee. Miss Kil-

patrick is in charge of the nursing activities in the Region "A" Attica and Boetia, assisted by Miss Ballam and Miss Esther Gilbertson, also from the United States.

There are fifteen of them altogether, made up of these three UNRRA nurses, a team of eight from the British Red Cross Society, under the leadership of Dr. Lowe from the London County Council, and three International Service Guides. The Guides are distributing food and clothing. We ran into them driving their trucks through the town and later, dusty and tired, some miles out in one of the burned villages.

These girls live the hard way, far removed from the barest necessities of life.

ALIKE IN APPEARANCE -



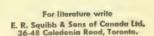
Tiny bodies, externally alike, may differ basically in their requirements of Vitamin D. That is why Squibb Cod Liver Oil comes in two potencies—Squibb Cod Liver Oil for normal babies and Squibb Cod Liver Oil with Viosterol 10D for premature or repidly growing infants.

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SEPTEMBER, 1945 733

UNRRA House, in which the three nurses live, is very bare and cold. "In Athens", Miss Kilpatrick said, "there is a wild scramble for a bath once a week. Here we are saved that trouble; we just don't have one at all". These girls live on Army rations; bread, margarine and jam. Tea is poured out of a huge enamel mug into earthenware cups with no handles. Bully beef and tinned salmon come up regularly in various forms and degrees of temperature. At night it is bitterly cold in the large bare bedrooms and one sleeps only if one can forget the chorus of countless barking dogs.

The girls start work at 8 a.m. There are a hundred-and-one unexpected tasks that they perform in a day. When we asked for a program of their daily round they laughed, "If we made a list", they said, "you can be sure that two-thirds of it will be scrapped for the dozens of little jobs that keep cropping up during the day".

Outside the gate at 8.30 a.m. people were already collecting. They were enquiring about clothing, where to find transport, a son had sore eyes, or a child was sick. A little blind boy, his head swathed in bandages, lay on the curb; his father stood helplessly by waiting for Miss Ballam to arrange for transport to take the child to Athens for treatment.

I had a feeling that these girls were expected to do anything and everything, including the performing of miracles. They are made of the right kind of stuff, and are dealing with each emergency as it arises.

During the bitter snows of February we learned that they did a very fine job treating the hundreds or more hostages and refugees from the mountains. Some refugees suffered from blistered feet; others from frost-bite and various other infections due to neglected cuts and wounds.

These girls cover an area of 268 villages between them, in which 68 per cent of the population are suffering from scabies and 70 per cent are suffering from chronic malaria and various forms of malnutrition. They bath and rub some 60-70 adults and children during a day with yellow sulphur ointment which the villagers have come to look upon as magic. "They feel cheated", said Dr. Lowe, "if they don't get any".

The villagers have come to love and respect these girls. Katina, the maid at UNRRA House placed her hands on the shoulders of

Miss Kilpatrick and Miss Ballam, and said, "These are our friends everybody's friends". Watching the efficient but kindly face of Miss Kilpatrick and the serious expression on the face of Miss Ballam at the hospital as she talked to a patient, I knew what she meant.

The need in the Lamia area is great. The prohibitive price of soap makes any kind of washing a luxury. Scabies cannot be cured whilst the people have no soap or a spare garment to change into. Atabrine is needed for the many cases of malaria. Cod liver oil is needed for the children. The demand for sulphur ointment is such that the nurses use what they have as precious gold. More blankets and beds are needed for the homeless children at the burnt orphanage where they sleep on the floor. People have been driven, sick and maimed, like sheep in search of food and shelter. Entire villages are destroyed without a single house standing. And they still smile.

That is why a handful of girls remain fighting against tremendous odds, what must seem at times a losing battle. This is the true story behind the scenes in Greece today. The desperate need of Greece is not found in the false veneer of a half-dozen shops in Athens, where a few luxury goods are sold at ridiculous prices. Even these are not the true Athens. We could afford to buy such things in pre-war days; they were not perched in the windows like dummies just to be looked at as they are today. Out in the burned villages, where the patched and dirty rags reveal ricketic limbs and bleeding gums, that is where we see the aftermath of a tyranny such as the world has never known.

- ISABEL HUNTER.

Travelling Around

We seem to be doing a bit of travelling since May, 1944. We've known Cairo, Alexandria, then another sea voyage, but a short one to Italy. I really enjoyed the absolute contrast. The Middle East was so hot and dirty that we welcomed the sight of the olive groves and grape vines in the south, although it was very dusty. Driving about in everything from a jeep to a tenton truck our clothes were always caked with grey dust. Then we gave up our lovely blue uniform, of which I am very fond, and donned this horrible khaki which is much more practical for the type of work which

JOHNNY CANUCK RETURNS TO

CIVILIAN LIFE — And whether he needed hospitalization or not, he will probably have to go through a period of readjustment to normal living.



One legacy, which many will bring from the rigors of war, is a topsy-turvy digestive system— a "delicate stomach"— which, for some time, may interfere with normal eating habits and nutrition.

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we are doing. I enjoyed my short stay in Naples. From there I flew to Florence where we did a spot of work. Now we have given up city life and have retired to the country, living in a quaint old village way on top of the mountains. I'm quite certain they will never get us out of here after the trouble they must have had finding the place originally. Tiny winding strets, paved with cobble stones, but by far the cleanest spot I have seen in Italy.

Tomorrow I am going into Rome to visit the Red Cross. Must try to scrounge a bit of equipment for our theatre, but they have been very generous on previous occasions. I do hope a vehicle will be provided for transport then we may have time to do a little sightseeing before coming back to the hills.

Next week they are sending me back to Naples to a British hospital for a three weeks' course in special eye work. Most of the eye casualties are sent to a certain centre and, as a result, they get more experience than the rest of us; so one operating theatre nurse from each hospital will go down for three weeks and learn what they can. I do hope I pass the examination at the end of that time for it has been a long time since I've had to do "any book larnin'".

-NURSING SISTER JUSTINE DELMOTTE.

Book Reviews

101 Clinical Demonstrations to Nurses. by Hamilton Bailey, F.R.C.S. (Eng.) 136 pages. Published by E. & S. Livingstone Ltd., Edinburgh. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1944. Price \$3.00.

Reviewed by Elsie Allder, in charge of the Teaching Department, Royal Victoria Hospital, Montreal.

In this book, the author has assembled a collection of "demonstrations" as an introduction to the study of clinical surgery. There are fifty-one such "demonstrations", really brief explanations of conditions commonly seen in surgery, and more than ninety photographs or illustrations. Dr. Bailey states clearly that

the apparently haphazard arrangement of the collection is intentional. He has introduced clinical material from the simple to the more complex.

Each condition is described as though the surgeon were giving a clinic at the patient's bedside. The descriptions are concise and clear; essential material is well-worded and stimulating. The photographs, with accompanying diagrams and x-ray pictures, should help the student to form clear mental pictures of the conditions discussed.

The author explains terminology in an interesting manner which should be helpful in remembering new terms, for example:

Pott's Fracture-Dislocation, page 32:
"Pott's fracture is better called Pott's fracture-dislocation, for there is usually a dislocation in addition to the fracture... In 1758, Percival Pott, surgeon to St. Bartholomew's Hospital, was thrown from his horse in the Old Kent Road. He sustained a fracture of his leg, and much of our knowledge of Pott's fracture-dislocation is due to the personal observation of his own case".

Graves' Disease, page 75: "The symptoms (as described) of exophthalmic goitre were first described adequately in Britain by Robert Graves, 1796-1853. He was a physician to the Meath Hospital, Dublin".

Charcot's Joint, page 116: "Jean Charcot created in the Salpetrière Hôpital, Paris, the greatest neurological clinic of all time. His Sunday morning demonstrations drew students from all parts of the world. He died in 1893".

This book should be helpful as a reference book for students taking surgical nursing classes. In a large hospital, it cannot be assigned to any definite course, as lectures in the various fields are entities, but might be more useful in smaller hospitals.

Human Anatomy and Physiology, by Nellie D. Millard, R.N., M.A. and Barry G. King, Ph.D. 514 pages. Published by W. B Saunders Co., Philadelphia. Canadian agents: McAinsh & Co. Ltd., 388 Yonge St., Toronto 1. 2nd Ed. 1945. Illustrated. Price \$3.50.

First published in 1941, this second edition retains the general plant of or-



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ganization into the five major units which proved such a useful teaching method in the initial edition. Unit 1 discusses the body as an integrated whole; Unit 2 describes the erect and moving body, including the skeletal and muscular systems; Unit 3 deals with systems which are concerned with maintaining the metabolism of the body, including, circulatory, lymphatic, respiratory, digestive, glandular and excretory systems; Unit 4 pertains to reproduction of the human body; Unit 5 shows how the body is integrated and controlled by the nervous system.

Abundantly illustrated with excellent line drawings, the factual material is written in a lucid, direct style which makes for easy learning. Each new term is simply and convincingly explained: "Fibroblasts are the common connective tissue cells. They are called fibroblasts because it is generally believed that they are responsible for the formation of inintercellular fibres". The information of each chapter is conveniently and concisely summarized, and two or three per-

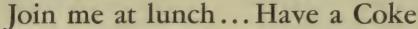
tinent questions are included for further discussion on essential points. Several new topics, which were not treated in the first edition, have been added. This is an exceedingly useful, a different textbook in anatomy and physiology.

Pediatric Nursing, by Abraham Levinson, B.S., M.D. 299 pages. Published by Lea & Febiger, Philadelphia. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 3rd Ed., rewritten and reset. Illustrated, 1945. Price \$3.45.

Reviewed by Madeleine Flander, Instructress, Children's Memorial Hospital, Montreal.

The author covers, in a little space, practically every unit of pediatric practice and pediatric nursing. This he has done by a direct, clear and concise presentation. The reader is left with the impression that here is a good summary of a vast subject, a summary in which all of the important points have been included without detail or elaboration.

The material is arranged in three





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municable diseases, I
Psychologic and So
of Child Nursing, th

parts. Part 1, General Considerations of the Child in Health and Disease, includes the newborn, growth and development. care of the premature, infant feeding, methods of examination and of treatment. These last two chapters, methods of examination and of treatment, are particularly helpful since they outline the common diagnostic procedures and discuss drugs commonly used in pediatric practice, including the sulfonamides and penicillin. In Part 2, the diseases of infancy and childhood are outlined in relation to the systems of the body. There is also inclusion of allergic and deficiency diseases and general considerations of the communicable diseases. In the last section, Psychologic and Sociologic Aspects of Child Nursing, the students' attention is directed to the expectant and perplexed mother and to the management of the "kind" grandmother. Thus with the discussion of the psychology and art of child nursing, the patient is seen as an individual and as a member of a family. This part of the text is short and concise as are the preceding chapters, but is valuable and interesting.

This book gives the bare essentials of pediatrics and of pediatric nursing. It is well illustrated throughout.

Skin Adhesive

Seldom is there richer reward for industrial research chemists than the knowledge that they have contributed in some way to the advance of medical or surgical technique.

A recent example of such a contribution is the development by chemists of the Paint and Varnish Division, Canadian Industries Limited, of a new adhesive cement for use in skin grafting. The story is told in the Canadian Medical Association Journal by Dr. J. W. Gerrie, in charge of the Plastic Surgery Centre, Montreal Military Hospital.

The meed for an adhesive cement with special properties arose in 1939 when a

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new method of cutting skin grafts was introduced in Canada. The new method consisted of applying an adhesive liquid to the skin surface and to a metal drum or plate which lifts the skin, enabling a graft of known calibrated thickness and desired size to be cut. The graft is then removed from the metal and placed in its new position.

The "adhesive" method had several advantages over older techniques for cutting skin grafts, but no available cement was without some practical disadvantages. Some of the properties required in the cement were that it could be easily applied in a thin, even film, would be non-irritating, sterile, readily diluted, easily removed from skin surfaces and instruments, non-corrosive to metal and would quickly become "tacky". A further extremely desirable quality was that it should have a greater affinity for metal than for skin to facilitate removal of the graft from the instrument.

"Canadian Industries Limited was approached and the problem placed before them," Dr. Gerrie states. "By trial and error over a period of nearly two years a liquid was finally evolved which belongs to the pyroxylin or nitrocellulose family of adhesives. This has given outstanding satisfaction and fulfilled the qualifying essentials enumerated above".

Dr. Gerrie goes on to state that bacteriological studies were conducted at the laboratories of the Montreal General Hospital and the cement declared safe for clinical use. "It was put into clinical use at the Montreal General and St. Mary's Hospitals, where several advantages over previously used media soon became obvious. The outstanding advantage lies in the fact that the cement has a greater affinity for metal than it has for skin. Upon removing the graft from the metal drum or sheet the adhesive appears to cling to the metal, leaving the skin surface clean and free".

The Company's chemists also suggested methyl acetate as a diluent and cleanser, and this, too, has been found entirely satisfactory.

The timeliness of this development needs no emphasis. Never has there been greater or more widespread need for the surgeon's skill in mending bodies that have been damaged and scarred. Small wonder that any who have had a part in providing the tools and materials needed to carry on this work should be filled with pride and satisfaction.

-C-I-L Oval.

Alberta Department of Public Health

The following are the staff appointments to, transfers and resignations from the Provincial Public Health Nursing Service of Alberta:

I. Jean Farewell and Frances Smith were recently appointed to the New Brigden and Newbrook districts respectively. Alice Thorneloe, from Vancouver, was recently appointed to the Sunnynook district.

Elizabeth Wallwork was recently transferred from Sunnynook to Craigmyle district. Dorothy Geeson relieved at Worsley during the summer before returning to university this Fall to allow Mrs. H. A. (Willis) Taylor to take up her housewifely duties there. Mrs. J. E. (Kaufman) McPhail is at present staying on at Kinuso.

M. Blake resigned from the staff this winter and is at present at home in Kitscoty.

M. A. K. Davis resigned as district nurse at Craigmyle and is now on the staff of the Foothills Health District, High River.

Thora McMullen recently resigned from Rocky Mountain House to be married.

NEWS NOTES

MANITOBA

Winnipeg General Hospital:

Doris Wellar, supervisor of the operating room, is taking a post-graduate course in operating room technique at the Toronto General Hospital.

NEW BRUNSWICK

ST. STEPHEN:

At a recent meeting of the St. Stephen Chapter, N.B.A.R.N., routine business was transacted, the treasurer reporting the pur-

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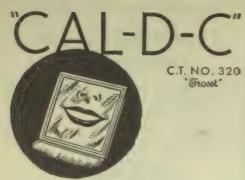
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THE RYERSON PRESS
TORONTO

chase of a Victory Bond. An interesting letter was read from Mrs. Elsa Dunbar, head of the Empire and Foreign Dept. of Voluntary Services, London, England, thanking Chapter members for parcels sent to them. The June meeting was held at the home of Myrtle Dunbar and was in the form of a picnic supper. Each member brought clothing, soap, and other articles for parcels for Britain, which are to be packed immediately and sent to London.

Chipman Memorial Hospital:

One of the largest classes in recent years was recently graduated from the Training School of the Chipman Memorial Hospital. G. H. I. Cockburn presided and T. C. McNabb of Saint John was the guest speaker. Diplomas were presented by Dr. S. R. Webber and the school pins by Miss Reta Follis superintendent of the training school. The Nightingale Pledge was administered by Archdeacon E. Hailstone and the invocation by Rev. D. C. McKenzie. Vocal solos were rendered by Mrs. Raymond Russell and Mr. Don Jamieson. A reception and dance was held later.

The annual meeting of the Alumnae Association of the Chipman Memorial Hospital was held at the cottage of Miss Annie Spinney at Oak Bay. Annual reports, election of officers and routine business was carried out. The members voted to present a thermometer to each member of the graduating class.

NOVA SCOTIA

HALIFAX:

Major Jean Nelson (Victoria General Hospital), Principal matron of No. 9 C.G.H., has been awarded the R.R.C. She recently returned to Halifax. P/M Nelson had the honour of taking over this hospital under Col. R. Forbes. Capt. M. B. MacNeill, R.C.A.M.C. (permanent forces). formerly Matron of Cogswell St. Military Hospital, has also been awarded the R.R.C.

Lieut. Muriel Graham, who went overseas in 1942 with No. 7 C.G.H., has returned to Canada and is stationed at Windsor, N.S. Lieut. Graham is on leave from the R.N. A.N.S. having been the registrar before en-

listing.

Mrs. Vera J. MacKenley (Victoria General Hospital), widow of the late Archbishop MacKenley, has been appointed Dean of Women at Kings University and commences her duties this Fall.

A very enjoyable "At Home" was held ecently in honour of nursing sisters recently returned from overseas. Mmes. A. L. Chaisson, J. O'Neil, H. Power, Misses A. Murphy, E. Trudel and E. Dunn assisted with refreshments and entertainment.

PRINCE EDWARD ISLAND

Through financial assistance from the Government Grant, the nurses were most fortunate in having this year an excellent refresher course in pediatrics conducted by Miss Madeleine Flander, instructor of nur-ses at the Children's Memorial Hospital, Montreal, and an Institute in Supervision by Miss M. Lindeburgh, director of the McGill School for Graduate Nurses. The attendance at both these courses far exceeded all expectations and all members present were greatly helped by the information that was given. The speakers were most generous of their time for informal discussions between sessions and did much to stimulate interest and enthusiasm among the members. At the latter course, two round table conferences, conducted by local nurses, and Miss Hazel Stearns, dietitian, illustrated very aptly many facts which Miss Lindeburgh had stated, and showed how co-operations are stated to the conference of the course o tion amongst the staff is essential in promoting good nursing service.

At the conclusion of each course the speakers were presented with a token of appreciation and grateful thanks were extended for their untiring efforts in making the courses successful.

Charlottetown Hospital:

Sister M. Magdalene, registrar of the P.E.I.R.N.A., has issued registration certificates to twenty-five nurses who have completed the provincial exams for registra-tion. Sister M. Irene, who has been attend-ing the University of Toronto School of Nursing for the past year, has returned to C. H. to take up her duties as instruc-tress of nurses. Reta Coady, who received a long-term bursary for study at the McGill School for Graduate Nurses, has completed the course in public health. Mae Morrissey, who took a post-graduate course in sur-gery at St. Michael's Hospital, Toronto, has been surgical supervisor at C. H. for the past seven months. Bernadine Morrissey has taken up her duties with the Mobile Unit of the Tuberculosis League. N/S's Joanne Mac-Donald and Mary Croken are spending furloughs at their homes, having been overseas for the past four years. N/S's Genevieve MacGuigan and Catherine Collings were recently married overseas.

P. E. I. Hospital:

The majority of our nursing sisters have been welcomed home from overseas. N/S Hattie E. MacLaine is receiving the congratulations of her friends, having been mentioned in despatches recently.

Jean Campbell has returned to the P.E.I. Hospital after completing a post-graduate course in surgery at the Royal Victoria Hospital, Montreal.



for infant's simple constipation, teething fevers, stomach upsets. A boos to mothers and nurses as an evacuant in the digestive disturbances which often accompany teething or which sometimes follow a change of food, where prompt yet gentle elimination is desirable. Sympathetic to baby's delicate system. No opiates of any kind. Over 40 years of ever-increasing use speak highly for their effectiveness. effectiveness.

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If any subscriber has these issues in their possession and would be willing to sell them, kindly communicate with the The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P. Q.

QUEBEC

Montreal General Hospital:

Seventy-three nurses recently received the medal and diploma of the Montreal General Hospital at the usual afternoon ceremony. Dr. F. J. Tees gave an excellent and inspiring address to the members of the graduating class. Col. Dorothy I. MacRae, R.R.C., Matron-in-Chief, R.C.A.M.C., presented the prizes. On the night previous to graduation, the Alumnae Association entertained the class at a delightful dinner. The guest speaker was Major General C. B. Price, C.B.E., D.S.O., who delighted the audience of two hundred guests with his observation of the splendid work achieved by the women of Great Britain during the war years. Mabel Shannon, president of the Association, was in the chair. We were pleased to welcome many nursing sisters that night, who had just returned from overseas.

sociation, was in the chair. We were pleased to welcome many nursing sisters that night, who had just returned from overseas.

Kathleen Clifford, surgical clinical instructor, recently spent ten days visiting the Presbyterian and St. Luke's Hospitals, New York, in a period of observation. Anna Christie and Mildred Brogan, instructors in nursing arts, also spent a period of observation at the Toronto General and Hamilton General Hospitals, N/S Catherine E. Doherty has accepted a position on the operating room staff at the Central Division. Miss Doherty recently returned from overseas where she served with No. 14 C.G.H.

It is with regret that we announce the retirement of Margaret Foreman as supervisor of the children's ward. Her place is taken by Elizabeth Colley whom we are pleased to welcome back. Flora Moroney, for the past two years health adviser and instructor, has also left the school. A tea was given in their honour and suitable gifts presented.

At a recent investiture in Ottawa, Lolita Best had the honour of receiving a decoration for her work in South Africa from the hands of Field Marshall Jan Smuts. In the King's Birthday Honour List, Dorothy Murphy received the Order of the Royal Red Cross, Second Class.

Royal Victoria Hospital:

The following resignations are announced: Elizabeth Hebb as charge nurse of the premature nursery, maternity pavilion; Pauline McKendry from the staff of the maternity out-door department; Geneva Purcell from the staff of the Ross Pavilion to become superintendent of the Brockville General Hospital.

Children's Memorial Hospital:

A successful "Swap Bingo" party was held recently by the Staff Nurses Association under the convenership of Laura Gray. A tennis tournament, including the staff nurses, affiliate student nurses, internes, and technicians, was concluded recently.

WANTED

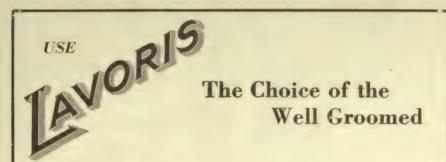
A class room Instructress for a 120-bed hospital. Apply stating qualifications, experience and salary expected to:

The Superintendent, Stratford General Hospital, Stratford, Ont.

WANTED

A 26-bed up-to-date hospital is under construction in Sackville, N. B., and the Hospital board is looking for a capable experienced nurse to act as Superintendent. Sackville is the home of Mt. Allison University, and is one of the most attractive towns in Eastern Canada. The Hospital will open about January 15, 1946, but the Board would like the Superintendent to be on hand November 1, 1945, or earlier to give advice. If interested please write:

Mr. Roy Durling, Hospital Board, Sackville, N. B.



You are using the best when you use Lavoris

Elizabeth Wood (St. Boniface Hospital), who completed her post-graduate course in pediatrics at the C.M.H. in 1944, is back on the staff. Mrs. James (Soullière) Delaney has been granted two months' leave of absence. Norma Craig, Helena Vaughn, Hazel Needham, Anne Dubé, Marie Leclerc, Della Tozer and Mrs. G. Cuthbert have resigned.

SASKATCHEWAN

MAPLE CREEK CHAPTER:

Blanche Treble, school nurse for the Maple Creek School Unit, is making her headquarters in Maple Creek. Mrs. Mitcheil (Elizabeth Stephens, St. Boniface Hospital) has recently been welcomed as a member of the Maple Creek Chapter.

SEPTEMBER, 1945

REGINA CHAPTER:

Attending the recent S.R.N.A. convention in Prince Albert were: public health, E. Smith, R. Doull, M. E. Brown and M. Pierce; hospital and school of nursing, M. E. Thompson; Regina Grey Nuns' Alumnae, Mrs. W. Martin; Regina Chapter, District 7, Mrs. D. Weaver, E. Worobetz; representing Regina Grey Nuns' student nurses, D. Read, a student taking the combined course at the University of Saskatchewan and Grey Nuns' Hospital.

Grey Nuns' Hospital:

M. Diederichs, instructor, has resigned. She leaves shortly to take up new duties at St. Joseph's Hospital, Victoria. F. Chenier, assistant instructress, has also resigned to take up private duty. Olga Tiegen, of the children's ward, has resigned and is to be replaced by Miss LaMuir of St. Boniface Hospital, Winnipeg. Rev. Sr. Gervais has been appointed supervisor following her lengthy term as night supervisor.

WANTED

General Duty Nurses, registered or graduates, are required for the Lady Minto Hospital. The salary is \$90 and \$80 per month, with full maintenance. Apply, stating full particulars of qualifications, to:

Lady Minto Hospital, Cochrane, Ont.

WANTED

A Superintendent of Nurses, Dietitian, and Instructress are required immediately for the Highland View Hospital. Apply, stating qualifications, to:

Secretary, Highland View Hospital, Amherst, N. S.

WANTED

Registered Nurses are required immediately for General Duty in Ex-Servicemen's Pavilion. Nurses are also required for Operating Room and Obstetrical Unit. Salaries depending upon experience. Full maintenance living out. Railway fare to Edmonton refunded after six months' service. Apply, stating experience, to:

Superintendent of Nurses, University Hospital, Edmonton, Alta.

WANTED

Applications are invited immediately for Staff positions with the Department of Public Health & Welfare, Halifax. Salary: Registered Nurses with public health course, \$1500-\$1800; Registered Nurses without public health course \$1320-\$1440. Uniforms, cost of living bonus, etc. provided. Apply, stating qualifications, age, etc., to:

Supervisor of Nurses, Department of Public Health & Welfare, c'o Dalhousie Clinic Bldg., Halifax, N. S.

WANTED

A qualified Instructress is required immediately for the Sherbrooke Hospital. Apply, stating qualifications, experience, and salary expected, to:

Superintendent of Nurses, Sherbrooke Hospital, Sherbrooke, P. Q.

WANTED

General Duty Nurses are required for a 350-bed Tuberculosis Hospital. Forty-eight and a half hour week, with one full day off. The salary is \$100. per month, with full maintenance. Excellent living conditions. Experience unnecessary. Apply, stating age, etc., to:

Miss M. L. Buchanan, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P. Q.

WANTED

Registered Nurses are required for general duty immediately. 250-bed sanatorium. Salary \$85 per month, full maintenance. 30 days holiday with pay per year. Apply to:

Lady Superintendent, Prince Albert Sanatorium, Prince Albert, Sask.

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1411 Crescent St., Montreal 25, P. Q.

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Registered Nurses Association of the Province of Quebec (Incorporated 1920)

Registered Nurses Association of the Province of Quebec (Incorporated 1920)

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Vol. 41, No. 10

FATHERS OF CANADIAN MEDICINE





Sir William Osler

MORE than any other man Osler exemplified all that was best in the tradition and practice of medicine. One of nine children, he was born in 1849 at Bond Head, Ontario, and obtained his professional education at Toronto and McGill Universities. In those early days students assisted a practising physician while at college. Osler's preceptor was Dr. James Bovell, a country practitioner of broad culture.

After studying abroad, Osler was given the Chair in Medicine at McGill University. Later, he was appointed professor of clinical medicine in the University of Pennsylvania; Gulstonian lecturer at the Royal College of Physicians, London; professor of medicine at Johns Hopkins University; and regius professor of medicine at Oxford.

His contribution to the profession of medicine was outstanding. To him is attributed the adoption of bedside teaching and the system of internship which afforded students an opportunity to obtain practical experience before engaging in practice.

Osler's text-book "The Principles and Practice of Medicine" was so clear, concise and comprehensive that is was adopted as the standard text-book of medicine by all English-speaking universities. It has been revised and expanded on a number of occasions. While at McGill, he published the "Pathology Reports" which were the first of the kind in America.

Osler was unselfish even to effacement. The generosity of his hospitality was open-hearted and his entertainment of guests delightful. He had a richly endowed mind. His name will live not only because of his great contribution to medicine but also because of his "little nameless unremembered acts of kindness and love." He was known and beloved in America, Great Britain and the Dominions.

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759 OCTOBER, 1945

Reader's Guide

We have much pleasure in welcoming as our guest editor this month, Barbara Alice Beattie, president of the Alberta Association of Registered Nurses. Born and reared in Nova Scotia, where her forebears had settled in 1803, Miss Beattie completed her education in Alberta, later graduating from the Calgary General Hospital. A brief flurry of private duty, five years of general staff work and Miss Beattie was called upon to assume the superintendency of first the Viking Municipal Hospital, and, later, the Drumheller Municipal Hospital, Following her graduation in hospital administration from the McGill School for Graduate Nurses, Miss Beattie took special preparation in psychiatric work and, since 1941, has been superintendent of nurses at the Provincial Mental Hospital, Ponoka, Alta. Her election to the presidency of the A.A.R.N. this year followed several years of active association with the work of the professional organization. As if all this were not enough, Miss Beattie golfs, curls, bowls, rides horseback and, when supplies are available, indulges in amateur photography and photo tinting. Under the able guidance of one with such a diversity of talents and skills, the A.A.R.N. is striding forward as Miss Beattie describes in her editorial.

It is eminently fitting that, with the close of the war, Fanny Munroe, president of the Canadian Nurses Association, should send a message to all the nurses of Canada. While the battles were in progress, the nurses everywhere responded with true fervour and patriotism. Can we do less now?

Dr. H. D. L. Goodfellow, psychologist, is director of education at the Ontario Hospital School in Orillia, Ontario. We are indebted to the R.N.A.O. for this paper which Dr. Goodfellow delivered at one of their meetings last Spring.

Dr. J. C. Meakins is Dean of the School of Medicine at McGill University. During the war period, Brigadier Meakins was deputy director general of medical services with the R.C.A.M.C. in Canada. His activities were recognized by the award of the C.B.E. Dr. Meakins has

long been interested in the problems of nursing.

Elsie Hickey, co-author of "Hospital Health Service", is director of the Division of Public Health Nursing of the Department of Public Health, Toronto. Violet Carroll is superintendent of the Hospital Health Service program which is carried out under the egis of and in co-operation with the Nursing Division. Much has been said and written about the possibilities of some means of effectively bridging the gap between hospital and home care. Here is one plan that really works and which might well be emulated in other communities.

Jean S. Clark, formerly secretary-treasurer of the National Public Health Section, was the efficient assistant superintendent of the Public Health Nursing Branch of the Alberta Department of Public Health. Her summary of the activities of the provincial public health sections shows that steady growth and progress are being maintained.

Gertrude E. Gibson is instructor of nurses in the school of nursing of the Brockville General Hospital. She believes in making chemistry a vital subject to her students. C. Doull is supervisor of the children's ward, Calgary General Hospital.

The interesting project to determine the accuracy of fluid intake recording was developed at Grace Hospital, Winnipeg, where M. E. Schumacher is clinical supervisor. E. Hartig was operating room supervisor at the Victoria Hospital at the time though she is at present at Deer Lodge Hospital, Winnipeg.

Newspapers have heralded the signing of a vast number of important documents in the past few months—United Nations pacts, unconditional surrender pledges and, no less important for the individual Canadians, applications for Victory Bonds. Our cover this month shows Fanny Murree, president of the Canadian Nurses Association, setting the example to all nurses. Sign Your Name for Victory — as a symbol of your thankfulness that Victory has been achieved.

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*Burke, B.S.: Nutrition and Its Relationship to the Complications of Pregnancy and the Survival of the Infant, Amer. J. Public Health, 35: 334-339 (April) 1945.

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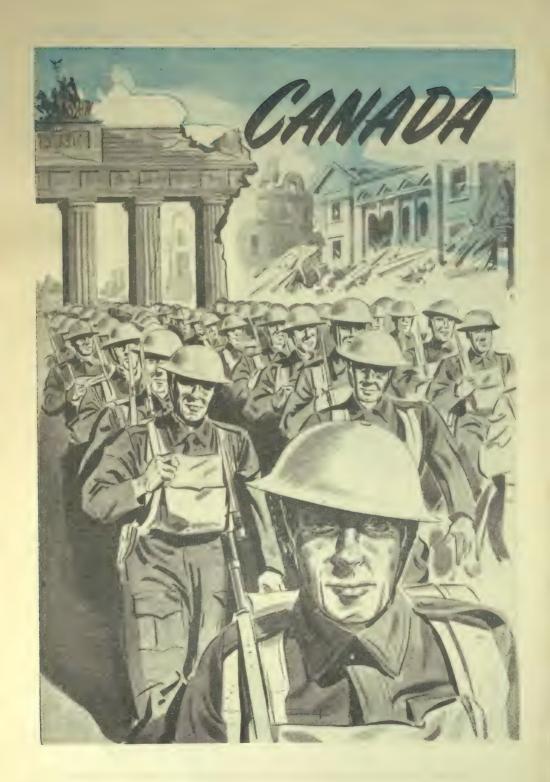
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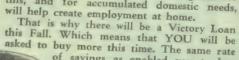
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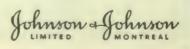
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The CANADIAN NURSE

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Alberta Looks to the Future

Western people are said to be fond of trying out new ideas and of being fearless in experimentation with new methods. Whether this be true or not, we now feel that the time is ripe for action in the matter of improving working conditions in hospitals, stabilizing hospital staffs and providing more social security for staff nurses.

There have been some excellent publicity and recruitment programs carried on throughout the provinces during the wartime years but we have been loath to attempt any investigation or criticism of conditions as they exist while hospitals are so heavily burdened with "more work and less staff".

At the present time, salaries for nurses are at a higher level generally than they have been for some years. Yet many of us can recall the not-too-distant past when salaries fell to an extremely low level. It was with the idea of standardizing salaries in hospitals as well as stabilizing hospital staffs that a com-

mittee of the Alberta Association of Registered Nurses was appointed to make a study of this question and to draw up a schedule of minimum and maximum salaries for all categories of nurses in all types of hospitals. This committee is to work co-jointly with a committee from



Rice, Montreal

BARBARA BEATTIE



the Associated Hospitals of Alberta who will report to their executive on the

progress made.

This schedule will include such information as yearly increments, vacations with pay, sick leave, hospitalization, as well as schemes for superannuation. Suggestions are being included for the benefit of hospital administrators regarding the organization and numbers of hospital staffs, of the need for special preparation for key people and the recommended hours of work for nursing staffs. This schedule will be presented to all nurses and to all hospitals for constructive criticism and the finalized form will be presented to the members of the Associated Hospitals of Alberta at their annual meeting this Fall for their approval and acceptance.

While this study has entailed a great

deal of work and many committee meetings, we feel that it has made us more aware of the need for projects of this kind. The organization of a placement bureau within the province, with the director making personal contact with hospitals, will also, we feel sure, help to unify hospital standards, and will bring the problems of our hospitals closer to our organization.

We are also convinced that the working together, in close co-operation, of these committees of the two organizations chiefly concerned with the care of the sick, will do a great deal toward the betterment of working conditions and the provision of more social security for the nurses of Alberta.

BARBARA A. BEATTIE

President

Alberta Association of Registered Nurses

To Do or Not To Do

The "cease fire" order has sounded in the greatest of all wars and from far and near prayers of thanksgiving have been offered by a world rallying to make a lasting peace. The nurses of Canada have cause to rejoice that it has been their privilege to do so much at home and abroad and that their particular knowledge and skill are now equally needed in the rebuilding of a shattered world.

The immensity of the task ahead is difficult to comprehend and this very thing is apt to confuse our thinking, making us regard as small that which is great — the care of the sick. That is our first responsibility.

For many years a stalwart band of nurses has stayed on the job in our civilian hospitals and to them the public

(and we all are part of the public) should give thanks. But the stalwart band can no longer alone shoulder the responsibility for the nursing of the thousands of patients in our general hospitals, tuberculosis and mental sanatoria. Who then is to do it? We hear that nurses want to get away from bedside nursing. This has been discussed already in a recent editorial in this Journal. We hear, too, that nurses no longer wish to work in institutions and this is being glibly repeated as if the entire fault lay in the institution. In both instances is there one common reason for this dislike?—namely that night duty must be done and nurses must be on duty on Sundays and holidays and in the evenings. Illness and suffering take no heed of time.

What then is the solution? We are told that women with little preparation did good nursing during the war years and undoubtedly they helped in the emergency. But would we wish them to nurse any one through a serious illness? Would we not be highly critical of an institution where such a situation existed? And would we ourselves not demand nursing care on all days and at all times? Have you or I the right to demand what we are unwilling to give others?

During the war years the Canadian Nurses Association has endeavoured to keep its professional house in order so that with the coming of peace we would be prepared to embark on an expanding program of service. To do this it behooves every nurse in Canada to study the trends in our present day nursing situation. If, in our considered judgment, some nursing duties can be delegated to a less highly qualified group, the responsibility becomes ours to ensure that these persons are so trained and supervised that none may suffer. It behooves us, too, not to emulate the Levite who passed by on the other side leaving the wounded one uncared for. If the thing nurses wish to do is allowed to take precedence over the thing we ought to do then will public opinion condemn us and nursing as a profession will be doomed.

FANNY MUNROE

President

Canadian Nurses Association.

Sign Your Name for Victory!

So the war is over! It seems hard to realize after so many weary months that there will be no more worry from casualty lists, that ships may sail at will through safe seas, untroubled by anything more treacherous than the hazards of storm and reef. Soon the thousands of young men and women, including our nursing sisters, will have returned to this, our peaceful land. We are all familiar with the scenes of excitement of exuberant happiness and, above all else, of thankfulness that our loved ones are safely home or soon will be. Yes, we may well be thankful that the war is over.

But wait a minute! Is it all over? In our joy at the safe return of our own family members and our friends, are we likely to become a little over-satisfied, a little blasé about the job that still remains to be done? Where there has

been so much destruction and desolation there must be enormous programs of rebuilding, of assistance to those who have been bereft, of re-instatement to such health and vigour as is possible for those who have been maimed. That, too, is expensive business. Again, Canada is calling for the loan of money to assist in the business at hand. Again nurses are being asked, not to donate, but to invest their money in the safest security obtainable — Victory Bonds.

The objective for this, the ninth Loan, is high but it is no greater than our resolve should be that Canada will play her role in establishing the peace, in assisting bruised and battered nations to find a new hope, and in defeating any tendencies to inflation. Let us demonstrate our faith by buying more and more Victory Bonds. Sign Your Name for Victory!

The Future of Nursing

J. C. MEAKINS

M.D., C.M., C.B.E., F.R.C.S., F.R.C.P., F.R.S.C.

The present course of training in nursing is one which demands not only a great deal of intellectual application, but also considerable physical endurance. Compare it, for instance, with the work leading to a bachelor of arts degree. This course usually covers 108 weeks, spread over some forty months, while the nursing course is one of 156 weeks, concentrated into thirty-six months. It will be seen that the course of study and training is not only longer, but it covers a shorter period of time. There are those who believe that the nursing course should be lengthened and there is much to be said in favour of this suggestion. There is, however, another group who believe that the present basic course in nursing is adequate to the purposes for which it is designed. Indeed, there are some who believe that such training is too elaborate to meet what might be called the simple technical aids in nursing. I will have more to say concerning this later.

We are living in a period of rapid change and the philosophies of the past must be reviewed in the light of future expectations. Up to comparatively recent times the principal outlet for the nursing profession was in what is usually called private duty nursing. In 1931, slightly over 60 per cent of the practising nurses on the register were so employed and only about 40 per cent followed other nursing activities. In 1943, twelve years later, the private duty nurses constituted only about 25 per cent, those engaged in hospitals and schools of nursing 50 per cent, while industry, public health and other activities claimed the remaining 25 per cent. This shrinkage of the number of private duty nurses has been the cause of much complaint by a certain section of the public.

It has been the fashion to blame the

shortage of nurses on their enlistment in the Armed Forces. These enlistments numbered around thirty-seven hundred nurses. I do not wish to bore you with too much arithmetic, but in 1943 there were about fifty-two thousand nurses in Canada. Of these, some twenty-five thousand were actually engaged in the practice of their profession, so that the number robbed from the general population by the Armed Forces was less than 15 per cent. Compared with the medical and dental professions this is a comparatively insignificant number, as there were about 40 per cent of the doctors and 30 per cent of the dentists of the country in the Armed Forces. There are other factors which are of much greater importance in bringing about this apparent shortage. Probably the first and most demanding has been a steady rise in the incomes of a large group of the population who can now afford the luxury of enjoying ill-health. This is reflected in the long waiting lists for private and semi-private accommodation in large general hospitals. It cannot be, surely, that there is more illness in the population with the present raised economic standards. Cannot it be that they are now taking advantage of an opportunity to have their frames and "innards" tidied up? It is interesting that the medical diseases are on the decline, except for high blood pressure, which has so often a psychological factor in the offing. Whatever may be the cause, the fact remains that private duty nurses are in greater demand with a diminishing supply. There are only a little over six thousand available now as compared to about fourteen thousand in 1939. It is also an established fact that there is a rapidly increasing requirement for well-qualified nurses in hospital positions, administration, teaching, public health,

etc., which now amounts to upwards of fifteen thousand of the nurses on the active register. This makes the requirements for the Armed Forces seem rather insignificant,

It may be asked where the other twenty-seven thousand nurses are employed if not in their profession. This is a question easily answered. Over twenty-five thousand are employed as housewives, and a mere eighteen hundred are otherwise engaged. It might be contended that this is a tremendous wastage of nursing education. With this I cannot agree, although I would like to see many more nurses available. Perhaps there is no course of study and training which prepares a woman for her place as a good citizen better than does that of nursing. She acquires a knowledge of the world, a sympathy for the underdog, and skills which are of great importance whether within or without the household. There is no reason to believe that the marriage rate is higher amongst those with a nursing training. As a matter of fact, it may even be lower, as many young women who enter the nursing profession become absorbed in its professional and humanitarian fascinations, which are of no mean order, and these protect them as an armour does, so to speak, from the onslaughts of biological and economic forces.

The training and professional services required of a private duty nurse have changed considerably in the last generation. The duties of such nurses, after graduation, could roughly be divided into three classes — first is the nursing care of the acutely ill medical or surgical case; secondly, the guidance of convalescents and, thirdly, the care of the chronically ill or chronic invalid. The professional qualities required in a nurse looking after these groups are not, by any means, identical. In the acutely ill medical or surgical case the nurse is required to do many technical and professional procedures which thirty years ago were unheard of. She is the physician's

or surgeon's right hand in more ways than one and many of the technical procedures, which she will be called upon to do, would not be required in the last two categories. Those who give serious thought to the matter of illness are convinced that convalescence and the care of the chronically ill should not be the responsibility of the active treatment hospitals. It is not only wasteful and extravagant, but the job cannot be done as well in such hospitals as in institutions of a simpler, but special character. It seems a popular opinion that convalescence is merely a period of interminable rest. Nothing could be farther from the truth. Convalescence requires just as dynamic and scientific an approach as does the acute phase of disease. It is not only based upon definite physiological laws, but also requires a psychological approach of a particular quality. During the past ten years, the evils of prolonged bed rest have been increasingly appreciated. The management of convalescence and the care of the chronically ill require special techniques which in many ways demand psychological discernment of the highest level and training in physical and occupational methods.

I believe that this can only be met economically when the nursing profession appreciates that the study and training of those who will be responsible for the convalescents and the chronically ill are of a different order, and require a different type of approach, and probably also a different age group than for those taking care of the acutely ill medical or surgical case. I firmly believe that a great deal of good and much economic and psychological gain would result from having a corps of women trained in the care of the convalescent and of the chronically ill, not only in institutions but also in private practice. There are few institutions outside of the Armed Forces that have tackled the question of convalescence in a scientific manner. The Armed Forces have appreciated the vital necessity of not only the physi-

cal and psychological re-education of the sick and wounded who are capable of continued service, but also the importance of these same disciplines towards rehabilitation to civil life. Certain of the industries are appreciative of these necessities and one of the principal difficulties has been to find men and women who are trained to accomplish this purpose. How many of you realize the dependence which many people acquire during a period in the security of a hospital? There is a submerged fear of meeting the outside world again which exists in direct proportion to the duration of the hospital sojourn. Therefore, this stay should be as short as possible and the transition from the environment of illness to that of convalescence should be definite and purposeful.

You may think that I am seemingly trying to avoid grappling with the problems of the future of the nursing profession. I confess that to a certain degree I am. I am perfectly convinced that the demand for administrators, teachers, supervisors, public health and industrial nurses will steadily increase and this will be accelerated in direct proportion to the progress of social legislation throughout the country. It is true that there will be also an increasing demand for social service workers who are the colleagues of the nursing profession in the operation of the so-called social security. Whereas this may slightly reduce the expected requirement for public health nurses I think, in the long run, with the more equitable distribution of health services to the people, on what might be called a county level, both these professions will become increasingly necessary to the medical profession to carry on the work which lies ahead. It is obvious at the present time that one of the chief deficiencies in medical services is the mal-distribution of doctors throughout the rural and sub-rural districts. This is equally so with the nurses and social service workers, but with the re-orientation of medical services and with the

proper distribution of the facilities and tools to carry on a personal health service, more and more nurses and social workers will be required.

It would seem to be the temper of present public opinion, and of governments which reflect this, that social legislation will develop a greater and greater demand for those facilities which will maintain health and inculcate a concept of health as distinct from that of disease. During the last century public health has made enormous strides forward. This is particularly reflected in the steady decline of morbidity and mortality from the communicable diseases. As a consequence the expectation at birth is now somewhat over sixty vears and at the present time about 30 per cent of the population are over fortyfive. By 1980 this percentage will have risen to forty. It is a well known fact that the acute communicable diseases strike at those in the younger age brackets, while the more chronic degenerative diseases, which require more prolonged convalescent nursing care, are usually to be found in the older age groups. As a consequence, with increasing longevity, the demands for nursing care will shift to those requiring prolonged convalescence and to chronic disabilities. Therefore, it is obvious that there will be an increasing need for a particular type of nursing. But is it logical that the nurse trained to care for the acutely ill, which necessitates a highly technical training in many ways similar to that required of a medical student, should be used to care for individuals who do not require such skilled nursing?

These matters may seem to be only of academic importance. I assure you it is quite the contrary. We are facing a situation today in the fight against tuberculosis, for example, which is almost catastrophic. This disease can only be mastered by finding the infectious cases and segregating them in sanatoria. The first stage is going on apace through the work of public health organizations. But

how about segregation? There has been a more or less successful campaign over the years for more beds. Now that we have them they cannot be used; indeed, wards are being closed in increasing numbers because of the lack of nurses. The tuberculosis problem is not an exception, but applies to mental hospitals, many general and rural hospitals as well. Where the wards are not closed the institutions are understaffed. The question naturally arises—will we ever have enough of the present calibre of graduate nurses to meet our requirements? I doubt it, unless this matter is viewed with a broader horizon and the graduate and specially trained nurse properly employed.

I believe we need more nurses specially trained in administration, education, public health, industry, operating room technique, psychiatry, midwifery, tuberculosis, convalescence, etc., but to supply all of these we would make serious inroads into the ranks of general staff nurses. Further, it would not be economical that such specialists should do all of the work required in these realms. They should be supplied with technical assistants as is done in other professions and occupations.

I do not think the medical profession has by any means solved its difficulties, but it has made some progress. The demand for graduate training has steadily increased; so it should in the nursing

profession, but within reason. Thirty years ago doctors were thought to be the only ones equipped to carry out certain technical procedures in chemistry, physics, bacteriology, etc. These are now much better done by technicians. Without their help the practical application of medical science would be impossible. So I believe it should be in the nursing profession and we have indications to this end. Two ancillary occupations are growing rapidly, namely, ward or nursing aides and trained attendants. Both will fill an increasingly important role. The former can relieve the nurses in many institutions of numerous nonnursing duties which are time-consuming and of a routine quality. I further believe there is an important place for the trained attendant or her prototype in the home. We must be realistic about present and future requirements. I do not suggest that the training of nurses should be depreciated or curtailed but we must take a broad view of our requirements. Unorganized planning will lead only to confusion and waste. We are on the threshold of an enormous expansion of nursing and all it implies, but this must be met not only by high standards where required, but also by fluidity and flexibility. No campaign was ever won by field marshals alone but by the combined efforts of every arm of the services, each working in its proper place and after its special training.

Training Defectives in Institutions

H. D. L. GOODFELLOW

Let us first view the question of the changing philosophy which has brought a new attitude toward training the mentally retarded. To use the most appropriate meaning of the word philosophy in this connection — the way — the

trend — the changing influence in thought toward the so-called defective.

Prior to 1876 there was no marked appreciation of the upper grade defective as a social problem; much less was there any organized association on this con-

tinent dealing with the subject of the mentally retarded. The sight of an obvious idiot or imbecile was commonplace in nearly every community. They were tolerated, baited, teased and usually neglected. No attempt at formal care was considered unless they became destructive or obstreperous and then they were relegated to jails or alms houses. Retarded family groups were looked upon as just "queer" and subsisted upon local charity.

There is no room for doubt that the more extreme degrees of feeble-mindedness — idiocy and to a certain extent imbecility — have been recognized from early times. For the Spartans, idiocy presented a social problem that was dealt with in the sternest eugenic fashion and obviously defective children are said to have been cast into the river or left to perish on the moutainside. The laws of Lycurgus countenanced the deliberate abandonment of idiots, a practice which was followed to a certain extent throughout Greece according to Cicero, and among the Romans also.

The Greek roots from which the word "idiot" is presumably derived are "iditas", a private person; or "idios", a person set apart, or alone: thus the old concept that such people are outside the pale of society. It was as such extra-social beings that the feeble-minded for many long centuries were commonly shunned, ostracized, derided, persecuted as witches and fortune-tellers, creatures considered incapable of human feeling, and, therefore, undeserving of human compassion.

The example of Christ's teaching as to the duty of mankind to the weak and helpless appears to have brought some alleviation to the lot of the mentally deficient, and from that time on there were sporadic instances of the recognition of social responsibility for the care of the feeble-minded.

Among the Turks of today and in some parts of Ireland and Brittany, the extravagant idea prevails that these defective youngsters are children of God. The American Indian also allowed these children of "The Great Spirit" to go unharmed. With such incidents the predominance of superstition is evident. As late as the days of the Reformation, Luther and Calvin regarded these mental incompetents as "filled with Satan."

The scientific approach came about 1798 with the work of Bonaterre, Itard, Seguin and Montessori. The first approach was through the physiological channel of sensory development. Originally it had been thought that these cases could be cured completely. Though progress was made in developing certain capacities, the objective never was realized but the viewpoint gained was a valuable one and is the basis upon which we work today. Though the defectives cannot be completely restored, their native endowments can be invested through proper training and brought to fruition with some measure of profit to the community of mankind. To paraphrase and better illustrate the point we are all born at a fixed intellectual level; we cannot change that level any more than we can change the number of our hands or our eyes, but we can condition and develop these capacities to the best possible limit.

About 1900 work began along the line of individual mental tests. In the years 1909-1912 these tests began to assume some import in the field of education and gradually acquired a popular appeal with their present-day influence in our sociology. An ever-widening understanding of the idea of mental limitation is permeating society. Coupled with this goes the idea of treatment and a more wholesome knowledge of institutions.

To treat the question of the defective in the community we should perhaps arrive at a true understanding of what a defective really is. When the topic of mental deficiency is discussed, no doubt you consciously conjure up a picture of "Mary", "Jimmie", or "Sa-

die" with whom you are so well acquainted, and are indeed quite certain they belong to this so-called variety of mankind. One should be able here to enumerate all the anecdotes and howlers so rare and so typical of some defectives. A proper index of these incidents would be as good as Stephen Leacock's "Literary Lapses", but I am sure would prove too distracting to our more serious vein of thought.

The mental deficiency act of 1927 says that: "Mental defectiveness means a condition of arrested, or incomplete development of mind existing before the age of eighteen years, whether arising from inherent causes or induced by disease or injury". That is the formal definition, but to further simplify the wording-mental deficiency in the higher grade defectives is a matter of social and economic incompetence. This social and economic incompetence is absent in varying degrees in different defectives. The more obvious require continual and complete care. The higher grades require training and direction of their native capacity. The high grade defectives remind one of the story in the Scriptures about the talents: defectives must definitely have their talents invested, i.e., through a sound appraisal and through good direction. No class of individual will reflect so clearly or so stringently the influences about them as the defective. Like a mirror they reflect their social pressures.

One must always bear in mind that defectives live more by habit than by judgment. They may be adult of stature but always child of mind. To adequately direct a retarded person we must continually repeat these facts, otherwise we will lose patience and fail to get the goodwill and co-operation of the boy or girl concerned.

This changing philosophy is further noted in the attitude of the courts towards offenders. Those suspected of intellectual limitation are examined, diagnosed and committed according to the

measure of their understanding. It is not so long ago that many of these cases were treated as sinners rather than as sick. Fortunately, with the application of psychological knowledge, these people who come in conflict with civil ordinances are recommended for care and training rather than punishment beyond their power of comprehension. We are gradually learning the lesson which intelligence tests have to teach. We no longer blame the mentally defective for industrial inefficiency, nor punish weakminded children because of their inability to learn, imprison or hang mentally defective criminals because they lack intelligence to appreciate the ordinary codes of social conduct. According to an old oriental maxim, "It is better to light one small candle than to curse the darkness". By our wider knowledge of the subject and more humanitarian views, the philosophy is definitely changing. The democratic maxim of today says that, "Education is the cheapest defence of the nations." There is certainly no doubt that proper education of the defective is by far the greatest protection for posterity and enables this group to make a definite contribution to society.

The contribution to society is in direct relationship with the degree and soundness of the training given to each boy and girl either at home or in an institution. We are here interested in the training of the higher grade defectives, those unrecognized but a few short years ago, i.e., the moron, border-line and dull normals. Let us here refer to them as intellectual inadequates, not as cases of gross defect. In the majority of cases if the boys and girls of these groups had had good home direction with evenhanded immutable justice they would not have been formally and publicly identified as mental defectives. However, for those that are identified a suitable form of care and direction is then necessary. We come now to the place of the institution and its allied links for training and rehabilitation.

Through time and development some of the misunderstanding and misconceptions about institutions are gradually being removed. It is our policy in Orillia that every interested guest receive some sound first-hand knowledge of the place of an institution of this kind in the social life of the Province. Each intelligently informed visitor can be made a good-will ambassador, a missionary to further a good cause, to offset untrue and nebulous rumour.

The institution at Orillia is blessed by many physical features in its geographical location but above all it is most fortunate in having a genial headmaster, a superintendent who is quiet, kindly, not easily perturbed and certainly not blown by the contrasting currents of flash notions. Such an atmosphere makes for a sound, stable organization. Changes and developments are not incidental — they are growth changes which, when gradually developed, have a purpose and a permanence in the life of the institution and its projective influence on the subjects trained.

Our school program is set up to teach the mentally defective child, rather than to teach academic subjects to mentally deficient children. In every field, the curriculum of training program is adapted to the pupil's ability and needs. The child must be able to achieve success and to arrive at a definite goal that is both desirable and useful, A reasonable goal must be set and teaching planned for this directly. Teaching on the level suitable for the normal child would be foolhardy. Too often pushing the child into an opaque strata of learning beyond his ability has many untoward and unpleasant by-products.

In planning for our boys' and girls' institutional life, we first make a sound appraisal of their physical, mental and temperamental capacities and arrange their initial placements according to these findings. We have a fitting motto which may have a wealth of meaning to you. It is, "From everyone according

to his ability, to everyone according to his need." In other words the program is almost individually planned to give the greatest happiness to and to produce the highest possible industrial efficiency from each person.

The institution of today is an entire community and indeed such communities are much larger and more complete in their public services and facilities than many villages in this Province. The Orillia institution consists of about 500 acres of land upon which much of the food and all the milk is produced. Academic school, sports activities and amusements, laundry and industrial facilities, hospital, x-ray, dental, psychological, dietetic, surgical and remedial programs all contribute to a general plan of happiness and well-being.

As I said before the public conception of institutions is much happier than it was some twenty years ago. Gradually the public has been made aware of the fact that these institutions are the property of the public and are only as good as public interest and public encouragement. Irregardless of the excellent quality of your staff their efforts are curbed without funds and wise cooperation.

In 1876 an association was formed by the officers of the American institutions for the feeble-minded. This association has gone through various name changes and today is known as the "American Association for Mental Deficiency." Before going on to an outline of the institutional training, a brief moment should be devoted to the objectives of this association. Some of these objectives are:

The construction of institutions for the feeble-minded.

Clinical and pathological investigation to determine more exactly the causes of mental deficiency.

Mental examination of all backward children. Early recognition of existing mental defects affords the greatest opportunity for the child. A complete census and registration of all mentally deficient children of school age.

The establishment of special classes for feeble-minded children in large towns and cities.

The instruction of parents of feeble-minded children.

Extra-institutional supervision of all defectives in the community.

The segregation of mentally deficient persons for institutional care and training with a permanent segregation of those who cannot make satisfactory social adjustments in the community.

Parole for all suitable institutionally trained mentally defective persons.

A mental examination of persons accused of crime and all inmates of penal institutions.

Special provision for defective delinquents.

The objectives as you can see require the co-operation on the part of teachers, social workers, parole officers, court officials, prison officers, physicians, psychiatrists, psychologists, nurses and all intelligent citizens.

The institution then becomes the hub of such a many-spoked wheel, and is only as good as its officers and employees irregardless of the physical grandeur of the plant. Adequate professional training, good personal orientation, and a realistic appreciation of the problems of the mentally deficient are particularly necessary in those institutional officers and employees whose work is supervisory or policy forming. There must be a free and frank interchange of ideas and ideals among all institutional employees, including the administrators, the supervisory officers, and the teacher and teacher-attendant groups. There must be a professional interest in the efforts of other workers in the field of mental deficiency and, above all, a professional attitude towards research and experimentation. The institutional worker must be permitted and encouraged to see his task as part of a larger social problem and to view his daily efforts as a valuable and essential social service.

Our institution for the mentally defective in Ontario has an enrolment in excess of two thousand patients made up of all levels from idiocy to the borderline groups. The educational objective for institutional employees is one of training and care for all. Everyone must come under some organized and stimulating development from the low grades to the high grades. We work on the basis that no one is so low grade they cannot learn something, even if it is only some measure of personal care. The imbecile can be trained to a point that he can be returned to his own home, fitted to live pleasantly and usefully with his family, or to fill some niche of service in the daily life of the institutional milieu. The moron, provided he has the proper temperamental capacity, is prepared for a resumption of community life.

The high grade cases begin training and orientation as soon as they come to the school. Following the induction program of examination and documentation an interview is arranged. Their particular problem and capacity is known and discussion is carried in the light of this knowledge. The institution is depicted as a large community in which good and bad company can be selected. It is amazing just what a fine social indicator these friendships make. They exemplify clearly the old adage, "Tell me your company and I will tell you what you are." At the termination of this interview a training placement is assigned. Such assignments are made, having cognizance of the type of work and the type of staff supervisor most suitable to the individual in question. Regular daily contacts ae made with their training department with a view to assisting both patient and staff member to become better acquainted. Regular monthly progress notes are kept on all cases and transfers from one training department to the other are based on these progress records. The entire plan is devised with the objective of fitting these cases for satisfactory harmonious placements in the community. Laundry, sewing and mending, general household tasks, domestic science, and dining room service cover the major items in the courses. The latter states of the training are endowed with wider social privileges, such as a special residence for a small select group providing normal living environment with personal responsibilities attendant upon these privileges. Free access to out-door sports and wider freedoms for town leave are given. Running in conjunction with the entire course is opportune reading and instruction in personal hygiene, social ethics and the mores. At the completion of this course a Colony House service in Toronto provides the guidance and final amelioration for the girls. The boys are placed directly from the school or through the Working Boys' Home in Toronto.

This Colony House plan has proven to be an indispensable medium of encouragement. It enables these girls to eventually experience the joy of achievement; an achievement still directed by a vise and tolerant hand.

With the progress of time and wider knowledge the public has made the transition from selfish and ignorant unawareness to the reality, that in words of Seguin, "God has scattered among us rare as the possession of genius - the mentally defective, the blind, the deaf mute, in order to bind the rich to the needy, the talented to the incapable, all men to each other, by a tie of indissoluble solidarity." The old bonds are dissolving; man is already unwilling to continue to contribute money or palaces for the support of the indolent nobility, but he is every day more ready to build homes and give annuities for the unfortunate, or infirm, the chosen friends of Christian philosophy. This transition is the corner stone—the token of a new alliance between humanity and a class. hitherto neglected.

Let us again remember, "It is better to light one small candle than to curse the darkness." May we still be enabled to continue this valuable work for pos-

terity.

Hospital Health Service

ELSIE HICKEY and VIOLET CARROLL

Hospital Health Service in Toronto dates from the year 1905, when Dr. H. C. Parsons, clinician in charge of the tuberculosis clinic at the Toronto General Hospital, requested the services of a nurse to assist him in the clinic and to do follow-up work in the homes of the patients attending. He realized that his work would not be as effective as it should be unless work in the clinic and the home could be co-ordinated. In response to this request, three members of the Board of Directors of the Hospital paid the salary of a nurse for one year. This brief experiment proved conclusive-

ly the value of the service and the necessity for it to be continued. It was also felt that this was a community rather than a hospital responsibility. Dr. Parsons then approached the Medical Officer of Health and recommended that this nurse be taken on the staff of the Department of Public Health and that her salary be paid by the city. This was eventually arranged and the first public health nurse appointed in Toronto was a hospital health service nurse. From this beginning, the Nursing Division of the Department of Public Health has extended its service into all the general

hospitals of the city. In the Toronto General Hospital, the hospital health service staff does the venereal diseases and tuberculosis work only, as this hospital has its own department and staff of public health nurses financed by the United Welfare Chest.

Hospital health service is one of nine units of the Nursing Division. The staff consists of eighteen full-time and two part-time nurses, six epidemiologists, two tuberculosis nurses and three clerical assistants. This unit gives full time service in five large general hospitals, part time in three smaller ones, and in four sanatoria. The total field staff of the Department accept the follow-up from hospitals as an important part of their work and endeavour to bring the total resources of the community, both health and social, into play as required in the interest of the patient and his family. This is done in exactly the same way as though the patient were ill at home rather than in a hospital. Many of the field nurses have had hospital health service experience, as it is considered good policy to rotate the nurses occasionally in order that the viewpoints of both hospital and community may be kept fresh in the minds of all.

The function of the hospital health service nurses is based on the following:

- 1. On behalf of the patient she acts as coordinator between home, hospital and interested agencies, by: (a) Assembling for the physician all factors bearing on the case, such as home conditions, type of care the patient will receive on discharge, etc.; (b) translating to the field staff the physician's orders for treatment and management in the home.
- 2. Health teaching and interpretation of the physician's orders to the patient or member of the family.
- 3. Assistance in dealing with problems and difficulties of patients, including mental adjustment to illness, and detection and referral of social problems.

The hospital health service nurses, OCTOBER, 1945

with the exception of two, give fulltime service in the hospitals to which they are assigned, and have an office in the out-patients' department. They are in regular attendance at the following clinics: pre-natal, post-natal, chest, diabetic, syphilis and gonorrhea, and in addition give service at the Hospital for Sick Children to the cardiac, eve, orthopedic and neurological clinics. The nurses assigned to the various clinics are also responsible for the same type of patient on the public wards. Other patients, both clinic and on the wards, are dealt with largely by referral. This close contact with the patients provides splendid opportunity for carrying out the function of the service as previously outlined.

Information, reports and requests for information are sent routinely to the field staff on certain types of cases from in-patient and out-patient service and on many others when follow-up work is indicated or the physician desires information. For instance, a report is sent to the district on the first attendance at clinic of every expectant mother. Conversely, the field nurse, in addition to the routine reports, sends to the hospital related information which she may have on any patient attending clinic or on the ward. Routine reports of home conditions are forwarded on every infant admitted to the Hospital for Sick Children, and similarly the physician's instructions for continued care are sent to the district nurse on every infant upon discharge or attending out-patients' department. Too, a report is sent on all suspect or contact tuberculosis patients attending chest clinic, with such information as length and type of exposure and any other data which have bearing on the

In addition to the regular hospital health service nurses, there are six public health nurses as epidemiologists in the syphilis and gonorrhea clinics whose duties include interviewing new patients, and locating and arranging for subsequent examinations of the contacts of

SERVICES OUTDOOR - 1945 HOSPITAL HEALTH and INDOOR

DIVISION Director NURSING

ASSISTANT DIRECTOR

Superintendent

HOSPITAL HEALTH SERVICE

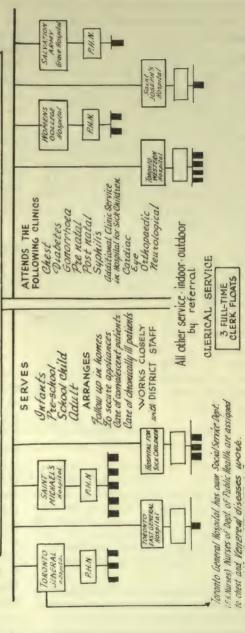
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these patients. The follow-up of attendance defaulters is the responsibility of the hospital health service nurse in charge of the clinic and the field staff.

Two nurses at stated intervals visit the sanatoria and provide the same type of service for the Toronto patients as is given in the general hospitals.

The following case illustrates the close working relationship between Hospital Health Service and district:

Mrs. B. brought her child to the outpatients' department following the school doctor's notification that the little girl's tonsils were abnormal.

At the hospital, the health service nurse enquired about Mrs. B.'s health, as it was apparent she was below par physically. She replied that her food did not seem to do her much good any more and admitted having lost over ten pounds during the preceding six months. She also had noticed she was increasingly thirsty and had been troubled with frequency. When it was suggested she remain for a medical check-up she said she was too busy to wait any longer and that all she needed really was a good holiday. The health service nurse told her that this could probably be arranged for her, but to ensure maximum benefit from a vacation she should first let the doctor determine her physical condition. She agreed and compromised by registering at clinic, leaving a specimen of urine, and making an appointment to return the following Thursday, (diabetic clinic day).

Somewhat reluctantly, she presented herself for examination as arranged. Her urinalysis report showed a four-plus sugar and the medical examination revealed that she was malnourished, and also somewhat anemic. Medication was given and she was referred to diabetic clinic. Later investigation proved that she was a moderately severe diabetic and the doctor referred her to our dictitian to have a 1500-calorie diet explained and then to the health service nurse for initial health teaching and to arrange for the patient to have 20 units of Protamine Zinc Insulin daily.

Mrs. B., who had been co-operative up to this point, declared quite definitely that she would not take insulin. Among other objections was a deeply-rooted fear that once

insulin was begun, it had to be continued throughout life. The dread of reactions seemed of greater importance to her than the danger of going into coma which the doctor had mentioned as more than a possibility if she persisted in her refusal. In view of her attitude, the doctor decided she might try diet alone for one week, during which time a request for assistance with her diet and her objections to insulin were sent to her public health nurse for follow-up. This procedure was of inestimable value, as she had known the nurse when her childien were toddlers and she said she would be glad of her help. She insisted, however, that even she could not persuade her to take

A telephone conversation with the nurse preceded our written summary and recommendations for this patient, and as Mrs. B. was receiving Mother's Allowance for her two daughters, aged 7 and 10 years, a supplement to her diet was requested and later obtained.

At her next visit to clinic, the doctor noted very little improvement in Mrs. B.'s condition and he again stressed the need for insulin. The patient said that since she had had time to thrash out the matter with the district public health nurse and had had the opportunity to have all her questions answered at the clinic in a way she could understand, she supposed she would be willing to try insulin.

A syringe, needles, requisition for free insulin and alcohol were supplied at clinic and arrangements were made to have a Victorian Order nurse call to administer the insulin for a week or so and demonstrate and teach Mrs. B. to prepare and give herself the injection. The public health nurse was notified to this effect. With the doctor's permission arrangements were made with a community social agency, through her public health nurse, for Mrs. B. and her two children to go to a farm for a month's vacation.

On her return, Mrs. B. had improved so much that the clinician allowed her to secure part-time employment as a sales clerk. With the money obtained she was able to afford her complete diet and was evidently quite happy in a feeling of restored independence.

These nurses, in their daily work in

the hospitals of the city, must surely assist in bringing to the hospital student nurses an attitude of mind and point of view which helps them to be more conscious of the total needs of the patient and the preventive aspects of nursing. The junior students have one or two lectures on the work; this is followed by a short period of observation with the hospital health service staff, and a halfday's home visiting with a district nurse. This is in addition to the community

observation of health work arranged for intermediate hospital students.

For over a quarter of a century the hospitals and the Department of Public Health, Toronto, have been working very closely together in the interests of the patients whom they endeavour to serve, thus putting into practice in an effective way the accepted philosophy that the hospital and the health organization are integral and related parts of a total community health program.

Recording Fluid Intake

M. E. SCHUMACHER and E. HARTIG

The fluid intake of a patient plays an important part in maintaining normal

body functions. A healthy individual seldom has any restrictions set upon the

Drinking cup small	3 na	6 € € € . € . '\$.
Drinking cup Large	37	1 50 c.c's
Water pitcher Small	3 xxii	780 c.c.'s
Water pitcher Large	3 xLvi	1,380 c.c.s.
Drinking glass	3, T	150 c.c.s.
Fluid glass	મુ ^{માં}	٩٥ د د . خ.

amount of fluid which may be taken. Most patients are permitted to drink as much water as desired so that no problem of measuring the quantity consumed arises. The nurse is expected to know, in a general way, if the quantity is sufficient to maintain normal body functions, such as digestion and elimination. In some cardiac and nephritic conditions the intake may be limited, and in communicable disease care fluids may be "forced". In either case the intake should be measured and it is the need for accuracy in making these measurements which presents a serious problem to the conscientious supervisor.

In the estimation of various student

nurses responsible for doing the measuring and recording during the course of one day, a drinking glass is thought to contain anywhere from 5 to 10 ounces. On the other hand, the different capacities of large and small feeders are seldom taken into consideration. In the light of the importance to treatment of the accurate gauging and recording of fluid intake, the "guess" method is practised far too frequently.

The accompanying chart was made to assist in the solution of this problem. The students were instructed to make the measurements of all the possible utensils used in giving fluids. These figures were discussed and standardized at a

	Cup Semi	3 vii	210 CC:5.
	Cup public	3 vii	210 C.C.S.
	Soup bowl	310	120 C.C'S,
The same of the sa	Silver tea pot	3 ×	300 c.c.'s.
	Silver coffee por	3.8	300 CC.S
23	Dessert dish	3111	90 c.c.'s.
	Soup bowl (1/2) ice chips.	3·iii	90 cc.s,

subsequent class. The "artists" of the group volunteered to make a number of copies of the chart for distribution to each ward. The results obtained have proved the value of this demonstration. Instead of making a haphazard guess, the nurses can estimate with a fair degree of accuracy exactly how much fluid the patient has consumed.

This experiment has accomplished a three-fold purpose: it was an instructive project for the junior students; properly mounted behind cleared x-ray film and placed in a conspicuous spot in the ward, it has proved a valuable permanent reference record; the measurement and recording of fluid intakes throughout the hospital have been standardized.

Contest Judges

Did you send in your entry in our recent contest or did you feel like the nurse who told us she "felt tongue-tied when she tried to write?" The number of entries was not as large as we had hoped for or anticipated from the thousands of nurses throughout Canada. Nevertheless, there were sufficient articles submitted to give our judges some work to do. That you may know who are responsible for the adjudication of these papers, here is the list of well-known nurses across the Dominion who are giving careful consideration to the entries: Pearl Brownell, registrar, Doc-

tors' and Nurses' Directory, Winnipeg; Mary P. Edwards, public health nurse, Weyburn, Sask.; Muriel Hunter, director, public health nursing service, New Brunswick Department of Health; Sister Denise Lefebvre of l'Institut Marguerite d'Youville, Montreal; Elinor Palliser, director of nurses, Vancouver General Hospital; Helen Penhale, chief of the Division of Hospital and School of Nursing Administration, University of Western Ontario; Mrs. C. Townsend, instructress, Montreal General Hospital.

-M.E.K.

An Important Publication

The I.C.N. announces the publication of The International Nursing Bulletin, a four-page successor to The International Nursing Review which was suspended in 1939 due to the war. The first issue of the Bulletin will appear in October, 1945, and will be complimentary. It will be published quarterly from then on, and will be increased in size and scope until it becomes a review of professional literature for its international subscribers.

The subscription price for four issues beginning January, 1946, is \$1.00. The price will have to be increased as the *Bulletin* is enlarged, but not during the first year. Please make your cheques payable to *The*

International Council of Nurses, 1819 Broadway, New York City 23, U.S.A. Send in subscriptions early as the number of copies of the complimentary October issue is limited.

Preview

What role does the hospital social service worker fill in our community health program? Wherein are her skills different from those of the average nurse? Mrs. H. Aline Paice outlines the history of the development of this group and, by practical example, shows us how valuable they are in the modern hospital.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A.

Application of Chemistry to the Practice of Nursing

GERTRUDE E. GIBSON

An often neglected but basically important subject in the nursing school curriculum, chemistry has been defined by Luras and Oram as: "The science which deals with the composition of substances and the reactions that these substances undergo on the application of heat, exposure to light and other conditions". Jevons has stated that "Chemistry is the basis of many useful arts". Of what practical value will a knowledge of chemistry be to the nurse, both student and graduate, in the practice of her profession? Does the present training in chemistry provide the nurse with the information it is essential she should have? Have the majority of our students had a sufficient background of information in chemistry that its application to nursing, and in particular food and nutrition, can be encompassed in a few introductory lectures? These questions are of direct concern to those who are interested in curriculum building as the answers to them are fundamental to planning the course of study.

In the Survey of Nursing Education in Canada, Dr. Weir stated that "Only a brief review of subject matter, with special reference to nursing theory and practice, should be necessary . . ." And again, "Over 75 per cent of the time devoted to chemistry . . . should relate to the medical application . . ." He suggests twenty hours for the combined

courses of chemistry and physics. The American Curriculum Guide includes an elaborate combined course of ninety hours. Our own Proposed Curriculum for Schools of Nursing suggests thirty to forty hours. The larger schools in Canada provide approximately twenty hours. Some of the small schools do not have any time allotted specifically to chemistry.

If the course as given deals only with the writing of formulae and equations, plus review of organic compounds and their detailed uses - an intensive review of high school chemistry - then it may be regarded as being relatively unimportant. It should give a better understanding of the physiology of the body when the anatomy course is studied. It should ensure an intelligent interest in chemical activities as related to the diagnosis and treatment of the various diseased conditions which the nurse will see. Finally, the student should develop a continuing appreciation of the contribution chemistry is making to preventive and clinical medicine through the development of new drugs and preparations. By simplifying, planning and reorganizing, much more could be done in our hospital schools "to make chemistry live".

So we say to the student throughout her course, to stop and consider: The pure water she drinks — how water

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functions as a medium in body processes and assists in the different types of elimination; why water plays such an important part in the spread and control of disease.

The changing of water to steam for sterilization; why the autoclave is very efficient for sterilization.

The reason for reduction of body temperature when a patient perspires profusely; why a patient is more comfortable after an alcohol sponge.

Why it is important to "force fluids" in a condition where diarrhea is present. Why normal saline is given after profuse vomiting.

The precautions that must be taken in the preparation of intravenous injections of isotonic solutions.

Why glucose is used instead of sucrose for intravenous injection.

Why she should be extremely careful in cleaning equipment that is used both for normal salt solution and silver nitrate solution.

The soap she uses — how it acts chemically with water; the various stains she bleaches and removes.

The antiseptics and disinfectants she uses—why bichloride of mercury is inefficient for disinfecting excreta.

The drugs and anesthetics in use — why it is a safe rule never to give two drugs together unless ordered.

Why egg albumin is used as an antidote in bichloride of mercury poisoning.

Why it is important to have urine examined while it is fresh.

The relation of the oxygen-carbon dioxide content of the air to health and comfort; the function of oxygen in the blood stream, and its relation to all life; why oxygen is administered to patients suffering from certain diseases and how the amount to be administered is measured; the precautions to be observed when an oxygen tent is in operation and why.

The chemical significance of asphyxiation by carbon monoxide. Why carbon monoxide is so dangerous.

The principles underlying the action of fire extinguishers in hospital use.

The chief value in using hydrogen peroxide in a wound.

Why it is necessary to watch the circulation in a patient who has had a plaster cast applied.

The importance of the preparation of the patient for a basal metabolism test.

The carefully prescribed diet that she carries to the patient. With modern methods of purifying and processing foods and the isolation of the vitamins, the selection of a safe and adequate diet would be almost impossible without an understanding of chemistry.

From the above brief outline of subject matter taken from various curricular subjects, it is evident that a knowledge of chemistry is basic and essential to an understanding of the principles and practice of nursing. Let us not overlook its worth in planning our courses of study.

Red Cross in Wartime

Since the beginning of the war the Canaian Red Cross has shipped 39,000,000 various articles and "comforts" overseas. Some 400 blood-receiving centres have been organized, and a total of 1,800,000 blood donations given. 5,500,000 items and comforts have been supplied to the Forces in Canada and 15,-000,000 articles despatched to the Forces overseas. Millions of sailors' comforts and "survivors' bags" have been furnished. 13,- 460,000 food parcels have been shipped by the Society to Empire and Allied prisoners of war. At the present moment 500 Canadian Red Cross Corps girls are serving abroad. In Great Britain, a 600-bed hospital was built and equipped by the Canadian Red Cross. Millions of articles of clothing have been supplied to civilian war victims.

-League of Red Cross Societies Bulletin

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses
Association

So Far . . . So Good

JEAN S. CLARK

Last month the chairman of our National Public Health Section, Miss Helen McArthur, shared with us in her article "Room to Grow In", her vision of the opportunities for expansion in the public health nursing field. There is a satisfying yet adventurous feeling in knowing that we belong to a profession in which there are always new avenues of endeavour. We can enjoy looking to the future of public health nursing, but we can also derive pleasure looking back on a job well done. Such was the feeling shared by the members of the National Public Health Section Executive when they reviewed the yearly reports from the various Provinces.

The public health sections in the Maritime Provinces have now been in existence for about two years. By their activities during the past year they have displayed all the vigour and enthusiasm befitting the youngest members of our group. The public health section in New Brunswick has pioneered in the field of publication, and now compiles and issues a quarterly newsletter. This newsletter, made up of material on newer developments in organization, public health, and medicine, is sent to all public health nurses in the province as a link to keep them informed and united. The public health section in Nova Scotia has directed most of its efforts this year to a refresher course on the Principles of Public Health Nursing, which was held in Halifax and repeated in Sydney during February and March. This refresher course was conducted by Miss Mary Mathewson, assistant director of the McGill School for Graduate Nurses, and proved most beneficial and stimulating to the one hundred nurses who registered. Although Prince Edward Island has only a few members in its public health section, a good attendance is reported at the quarterly meetings. Papers on practical subjects were presented with lively discussion in which all participated.

The members of the public health section in Quebec were fortunate to be able to avail themselves of a series of lectures given under the auspices of McGill University entitled "Lectures in Living", the main topic covered being "The Family in Transition". This series included eight lectures given by eminent American sociologists, psychologists and psychiatrists. This public health section has established a lending library for the use of any public health nurse in the province. This library, organized in April, 1944, is temporarily housed in the office of the registrar and executive secretary. A list of the available books is sent to each public health nurse in order to encourage her use of these facilities. The national section commends this very worthwhile activity.

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All the local groups which comprise the public health section in Ontario reported a very successful winter. Dinner meetings seemed to be the most popular means of getting together, and were held quarterly in some districts, monthly in others. There are a few districts yet where public health nurses do not meet together as an organized group, but several have expressed their intention of organizing in the near future. The Ontario nurses have had the opportunity of attending various refresher courses and lectures during the year. The University of Western Ontario provided courses during February in School Nursing; Supervision in Public Health Nursing and Hospitals and Schools of Nursing. A series of talks and discussions on "Mental Problems and Adjustments" under the leadership of Major Hobbs, R.C.A.M.C., was held in London. The University of Toronto School of Nursing held a refresher course in Industrial Hygiene, and there has been a request from the industrial nursing group that two such courses be held again during 1945.

After reading about the Manitoba Student Nurses' Association in The Canadian Nursez, it was most interesting to hear that the public health section had been hostess to this group. In an effort to stimulate interest in public health in the Student Nurses' Association (referred to as the Junior M.A.R.N.), the public health section invited them to participate in a panel discussion on the subject "What My Profession Offers Me". The public health section reports working in co-operation with the other two sections to produce a pantomine entitled "Co-ordinated Effort" which was presented at the annual meeting of the Manitoba Association of Registered Nurses. An Institute on Family Relationships was held at the University of Manitoba during June, under the direction of Miss Frances Benjamin of Minneapolis.

The public health section in Saskatchewan has held monthly meetings. This year the group has studied the book, "Your Community", by Joanna Colcord, with particular reference to Regina. There are public health nursing groups functioning in Regina and Saskatoon, with tentative plans drawn up for organizing in Yorkton and Moose Jaw.

The public health section in Alberta has been directing its attention to the industrial nurses of the province. A definite attempt has been made to include the industrial nurses in the public health section. A recommendation has been sent to the Council of the Alberta Association of Registered Nurses requesting that an institute in Industrial Nursing be held under the auspices of the School of Nursing, University of Alberta. Tentative arrangements for this course are now underway.

The last province to report on is British Columbia. This year, the section has been studying the subject of tuberculosis legislation, and an excellent report has been presented by the Educational Committee on their progress to date, accompanied by recommendations which were submitted to the Council of the Registered Nurses Association of British Columbia. The industrial nursing group in British Columbia held monthly meetings as a sub-section of the public health section. The chairman of the public health section attends their meetings and carries back to the Council of the R.N.A.B.C. any recommendations which the industrial nurses wish considered.

In this resume of sectional activities it has been impossible to give a complete report of each provincial section. The newer lines of development chiefly have been emphasized, though many routine activities have also been carried on in co-operation with the National Section. Contact has been maintained by the provinces with the National Section through their progress reports. The response to a letter sent out by the chairman of the Publications Committee requesting each province to send in an

article on some phase of public health work, of particular interest in that province, has been encouraging. A questionnaire, compiled by the Education Committee on "The Use of the Volunteer in Public Health Nursing" has been distributed to the agencies in each province through the provincial sections.

The National Executive has directed the provinces to make a concerted effort to include the industrial nurses in their sections through a recommendation sent out to that effect. In line with this, a Standing Committee on Industrial Nursing has been recommended to the Canadian Nurses Association Executive, as one of the Standing Committees of the National Public Health Section.

It has been said that growth is the only evidence of life. Your National Executive feels this report is ample proof of the "life" of public health nursing in Canada today. We can look back on the past year and say "So far . . . So good".

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Jungle Weapon

It is difficult to stump the chemist. In war years he has been called upon to meet the most exacting demands, and he has done so either by new developments, or by discovering new uses for materials taken from some corner of chemistry's well-stocked shelf.

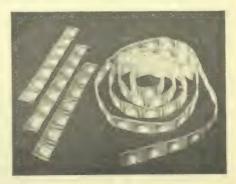
Take, for instance, the "dyestuff" that has been used to combat malaria and the "compressed gas" package in which it is supplied to soldiers.

When the Japanese captured the East Indies the Allies were cut off from their main source of quinine, which up till that time had been the most effective anti-malarial drug known. Turning as usual, to the chemist for help, military authorities were assured by Imperial Chemical Industries Limited of Great Britain of immediate, large-scale production of mepacrine, which is superior to quinine in many respects. Chemically, mepacrine is a yellow dye. In the United States it is known as atebrin or atabrine.

It was found, however, that mepacrine tablets dissolved or deteriorated in the damp heat of tropical jungles. An entirely new method of packaging had to be devised and experts tried all ordinary materials without success. Again the chemist came to the rescue. Someone thought of the known properties of the recently discovered plastic, polythene.

Polythene is made by polymerizing ethylene gas under pressures comparable to those in a gun. Under these terrific pressures the gas molecules fasten one to another somewhat like a mass of intertwined paper clips. The flexible, tough, crystalline solid that results found its first use as insulating material, and was largely responsible for successful production of the radar equipment without which Britain might have gone under in the dark day of 1940 and 1941.

Polythene can be produced in many forms, including thin, flexible sheets which are both waterproof and retain their flexibility at



A polythene strip holding seven individually sealed tablets.

temperatures varying from that of ice on the one hand to boiling water on the other.

When tried as a packaging material, the most rigorous tests showed that not only was it unaffected by tropical heat but that the mepacrine tablets wrapped in it could be left lying even in salt water for months and emerge as fresh as when they were packed. British engineering skill solved the further problem of how to get the tablet into its individually sealed compartment in the ribbon-like strip of polythene. From that time on, polythene was mepacrine's indispensable ally in the anti-malarial war.

Canadian soldiers who fought in North Africa, Sicily and Italy are well acquainted with the little yellow tablets that were handed out to them by the millions. Medical officers were more than satisfied with the results of their anti-malarial campaign and special mention was made by Generals Eisenhower

and Montgomery of the low malaria rate among Canadians.

On the Burma front a week's supply at a time, a strip of seven pockets, is issued to the troops. Each day one pocket, containing the daily dose, can be torn off the strip, leaving the rest safely protected from air, heat and moisture in its polythene wrapping.

A weapon like mepacrine in the antimalarial war is scarcely less important than any of the weapons that have been designed for combatting Nazis and Japs. This holds true even from a military standpoint, to say nothing of the untold sickness and suffering mepacrine has prevented. The largescale production of mepacrine, and the development of its unique packaging material, polythene, represents a double triumph for British chemical skill and engineering.

-C-I-L Oval

Sky Meals Present Dietetics Problems

How would you feel as a hostess if your sponge cake suddenly collapsed and hardened? Or if your whipped cream suddenly expanded to several times its original volume?

Suppose the bubbling water poured over the tea leaves turned out to be heated not to 212°F., but only 180? What if all your guests simultaneously developed indigestion?

These are only a few of the accidents that might happen in the cabins of speeding airliners if airways caterers were not armed with a knowledge of the effects on food of rapid changes in altitude, air pressure and humidity.

In a commissary close by Dorval Airport meals are prepared to be served during flight on five different airlines. A staff of about a dozen experienced girls work there under the direction of Jessie McDonald. Thanks to her passion for research and perfection, today's air travellers cannot expect to see cakes collapsing, sauces disintegrating and other disturbing phenomena at high altitudes. She now knows just what can and cannot be served aloft, just what foods will and will not stand up to flying conditions.

Plane meals are appetizing and satisfying without including an array of sweet or spicy things that might tempt passengers to overindulge and risk the onset of indigestion which often results from a combination of a full stomach and high altitude. Always excluded are sponge cake, whipped cream and other items which are known to behave capriciously when subjected to sudden changes in air pressure.

---C-I-L Oval

Preview

For many years now there has been more than enough work to keep every available nurse busy, be she young or old, single or married, fit or only half-well. It is reasonable to suppose that there will be a gradual tapering off of the demand for the skills and services of some of these nurses. In an attempt to solve some of the problems which may be presented in this period of readjustment, the eminent psychologist, Dr. S. R. Laycock, will discuss for us "The Adjustments of the Older Nurse" in our November issue.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

A Changed Picture

C. Doull

All over our country today people are talking about that "wonder" drug, Penicillin, and how it has changed the picture in so many cases from that of hopelessness to one of complete recovery.

Recently we had a very interesting case of osteomyelitis in our children's ward. He was a boy of nine years of age from the town of Didsbury, some sixty miles north of Calgary. He had first been sent to the Isolation Hospital in Calgary when the diagnosis of poliomyelitis had been made by the local doctor but, after a consultation with the orthopedic surgeon here, it was decided to transfer the child to the isolated unit of the children's ward at the Calgary General Hospital.

On arrival the boy looked acutely ill. His cheeks were flushed and his eyes were heavy. At times his speech was incoherent and irrational. Breathing was heavy and his tongue was coated. His pulse was very rapid and his temperature was 105°. There was some swelling of the left lower leg with tenderness in the upper third of the tibia. The boy moved his leg in flexion and extended it at times, but at others he complained of pain in his knee and upper leg on movement. The white blood count was 18,-200 with 82 per cent polymorphonuclears. The x-ray showed a definite bone abscess in the left upper tibia. The

prognosis was poor and the child's parents were given little hope of his recovery, as so much time had already been lost before a definite diagnosis could be made.

On the night of admission an intravenous with an initial dose of 10,000 units of Penicillin in distilled water was given; also a blood transfusion and supportive treatment. Penicillin was then given intramuscularly every two hours. The following two days the temperature remained between 104 and 105 dropping to 103, but toxicity still continued and operation was undertaken on the left tibia.

An incision was made along the tibia, the abscess drained and sulfathiazole powder and vaseline packing were inserted. Every day a definite improvement could be seen in the boy's condition. In three days after operation the temperature was normal.

After four days Penicillin was reduced to every four hours and, five days later, was discontinued. Two weeks after operation the packing was removed and fresh packing inserted. A cast was applied to the leg. A few days later he was discharged from the hospital.

He has been back twice since for a change of packing and cast, and the x-ray now shows decided improvement.

We have had other cases of pneumococcic meningitis and lung abscess where

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Penicillin has been used, and there appeared to be complete recovery. We are all looking forward to the day when Pencillin will be supplied freely for civil-

ian use and we know that, with its use, there will be a more complete and speedy recovery from many infections which have resisted other treatments.

Would You Make a Good Counsellor?

A nurse may wonder whether she has the inherent qualities needed by the successful counsellor. Some questions which she should ask herself in deciding whether she is interested in this field and has an aptitude for it are suggested here:

Do I have a genuine interest in people? This interest is fundamental for all nurses; for a counsellor it is indispensable.

Am I a good listener? A counsellor must listen attentively and sympathetically to the nurse's problem if she is to be helpful.

Am I sensitive to the reactions of other persons? Finding the latent potentialities in a nurse requires intuitiveness and perception.

Do I have patience? A counsellor must seem unhurried in her interviews, so that the nurse's total problem may be brought to light.

Am I tactful? Tact is essential, especially if criticisms from employers are to be presented by the counsellor to the nurse in such a way that she may grow professionally.

Am I able to inspire confidence? If nurses are to look to the counsellor for guidance, this quality is essential.

Am I kind and reassuring? These are also indispensable qualities in the counsellor if she is to help the nurse over the hurdles of hard times and personal tragedy.

Am I adaptable, so that I can adjust to changing conditions?

Do I have the vision and perspective to interpret changing demands in the field of nursing so as to guide nurses in preparing themselves to meet new needs?

Do I have the personal qualities necessary for meeting the public? Such qualities include a carefully groomed, attractive appearance, a well-modulated voice, poise, and a gracious manner.

Do I have the ability to speak easily before a small group? This is essential, because the counsellor is often asked to interpret the services offered through the centre, to solicit community support, or to meet with community groups interested in health problems.

> -Bulletin of the California State Nurses' Association.

Projected College of Nursing

The report of the 1945 conference of the New Zealand Registered Nurses' Association which appears in *The New Zealand Nursing Journal*, March, 1945, presents many features which will be of interest to Canadian nurses. In her presidential address, Miss L. M. Banks laid great stress on the importance of special preparation for nurses to fit them "to fill positions of ever-increasing responsibility".

"When the future policy of the Registered Nurses' Association is so bound up in two main objectives, namely, health and education, it does seem that the time has now arrived to give some thought to the formation of a central reserve fund with which a College of Nursing might be established. Such a scheme may sound grandiose, beyond us in this country - and even perhaps unwarranted - but, as nursing is one of the most important of the community services, it does seem that, as part of reconstruction policy, ways and means could be found, even on a large scale, to build up such a fund. We would not need a large piece of land, nor a large ornate building, but one suitably planned for our future needs. In this building - our future college - we could make provision for a conference hall and lecture halls where post-certificate and refresher courses would be held. The reference library of our Association would be there, and provision could also be made for the offices of the Association."

Nursing Education

Contributed by

COMMITTEE ON NURSING EDUCATION OF THE CANADIAN NURSES ASS'N.

A First Aid Qualification for Nurses

There is probably a natural assumption that nurses are, by reason of the fact that they are nurses, qualified for first aid. They have had considerable experience in acute situations, and they often have to take action in an emergency when the doctor is not present.

However, at the beginning of the war nurses quickly found that this assumption was not shared by others. When a Civilian Defence official had to specify a generally recognized qualification for first aid, he could name only the well-known St. John Ambulance preparation and certificate. Doctors were, needless to say, not asked to take a St. John Ambulance Association course to practise or teach first aid; but a nurse, no matter how experienced, had to take a very elementary course designed for lay workers before she could become part of a Civilian Defence organization. A Canadian Nurses Association Committee set up a course which utilized the nurses' more extensive background; but to teach this to student nurses or volunteer workers, the nurse had to obtain the certificate of the St. John Ambulance Association.

Absurd as this situation was, it nevertheless caused nursing educators to examine very carefully the training in first aid which was being given to student nurses. This inspection undoubtedly revealed some deficiencies. In general, it may be admitted that the training of nurses in this field was directed largely to meeting surgical emergencies as they

arose in the hospital or home and in cases already under the care of the doctor. Volunteer first aid workers have been more ready to tackle the accident on the road, and this has not been entirely due to the confidence engendered by a little dangerous knowledge. Also, members of the St. John Ambulance Association are required to keep in continuous practice, and this is obviously very important if a person is to be ready in an emergency.

Last year the Committee on Nursing Education was asked to submit suggestions for a first aid qualification for graduate nurses. This was done and now the Committee has been instructed to proceed with a syllabus and the plans for putting this into operation. In general, the plan will suggest that the Canadian Nurses Association establish a first aid qualification, with a certificate awarded by the Association on successful completion of an examination. Following this each individual nursing school would decide whether it would prepare its students for this Canadian Nurses Association certificate. The suggestion will be that this teaching should be given as part of the nurses' basic training, but that provision should be made for graduate nurses who wish to obtain the qualification. Those graduates who already hold St. John Ambulance or Red Cross certificates will be considered qualified.

In this course, emphasis should be placed on actual accident situations, and the practice be in terms of such situations. In traffic accidents, patients unfortunately do not usually each have merely one injury on which the first aid

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worker can concentrate. The nurse should have a great advantage in her ability to assess the patients' general condition and to decide what is most urgent. She should be able to see that no further damage is done through her efforts to help. As one specific example, we have been told that many cases of simple skull or spine fracture have been converted into brain or cord damage through improper methods of moving the patient, or through not refraining from moving him at all.

The purpose of this Page is to inform the Canadian Nurses Association membership of the lines along which your Committee on Nursing Education is working, in order that you may think with us, and that the plans of the Committee may not be entirely new to you when they are considered by the Executive Committee. This question of first aid training is one of the current projects of the Education Committee and we ask you to give it some consideration now.

Streptomycin Being Studied

A new drug, streptomycin, companion to penicillin as a killer of bacteria, is being studied and undergoing tests to determine its suitability as a germ killer. The new drug shows possibilities which may prove to be as important to the medical profession as was the discovery of penicillin. Streptomycin is a killer of gram-negative bacteria, such as tuberculosis, cholera, dysentery, typhoid, tularemia and salmonella food poisoning. Penicillin is a killer of gram-positive bacteria, such as pneumococcus, streptococcus, staphylococcus, gonococcus and syphilis.

Even though the new drug is still in the laboratory stage, some is being produced and small quantities are being made available for experimental purposes. Since streptomycin and penicillin resemble each other in many respects, experience gained in the production of penicillin will aid materially in the production of the new drug. The produc-

tion process, however, is slow and tedious and it will be some time before the drug is available in any quantity just as it took more than two years to bring penicillin into production for general use.

Dr. Selman A. Waksman of the Department of Microbiology of the New Jersey Agriculture Experimental Station at Rutgers University, New Brunswick, N. J., is given credit for the discovery of streptomycin. Ever since the discovery of penicillin, medical department and civilian bacteriologists, as well as army and commercial laboratories, have been searching for a drug that would fight the diseases that penicillin cannot cure. Dr. Waksman reported that he had discovered streptomycin and had reported on it some twenty-nine years ago during experiments with soil bacteria.

-News Notes, No. 26.

M.L.I.C. Nursing Service

Olive Carrier (St. Mary's Hospital, Montreal, and University of Montreal public nealth course) recently resigned. Miss Carrier was Metropolitan nurse in Joliette, P.Q.

Claire Lalancette (St. Jean de Dieu Hospital, Gamelin, P.Q.) has resigned from the

Company's Service. Miss Lalancette was on the Montreal staff.

Gertrude Lapointe (St. Vincent de Paul Hospital, Sherbrooke, and University of Montreal public health course) has been appointed to the Metropolitan staff in Montreal.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

News from Abroad

A national study of the nursing needs of the future, both from the professional and public points of view, as to education, distribution and standards, will be undertaken in a five-year program, it has been announced by the National Nursing Planning Committee of the National Nursing Council for War Service in the United States.

It is estimated that the program will require approximately \$500,000, and initial work is assured through a recent grant by the W. K. Kellogg Foundation for co-ordinating the work of the Committee itself. Support will be sought from other sources for specific studies and demonstrations. A major undertaking will be the study of schools of nursing, their number, size, location, organization, and financial and administrative control recommended in order to supply the kind and number of nurses needed in post-war America. Increased wartime responsibilities shouldered by professional nurses, as well as those arising from the development of medical specialties, have been considered in formulating the composite program; so also has been the effective way in which certain duties have been shared by subsidiary workers, Red Cross nurses' aides, etc.

Looking to the future, the program takes into account the increased need for well-prepared nurses which would result from the expansion of health facilities and hospitals, proposed by the United States Public Health Services.

Among specific topics listed for study or review are: the existing personnel policies and practices; testing of selected applicants for schools; financial aid for students; counselling and placement bureaux; professional registries; community nursing councils; implementation of standards and greater uniformity in State laws.

Such a broad study, to determine how far the war has affected the whole field of nursing and what the nursing needs of the future will be, merits the wholehearted interest and support of the nursing profession and public alike.

India Exhibition

The president of the Trained Nurses' Association of India will represent the International Council of Nurses at an exhibition to be held in Delhi in September. She has requested all available material on possibilities of training in general nursing, health work, midwifery and post-graduate training throughout the United Kingdom, Canada, America, Australia and New Zealand. We are glad to report that the Canadian Nurses Association prepared and sent to India material concerning all fields of nursing in Canada.

Comments on Narcotic Regulations

We are indebted to the Central Registry of Graduate Nurses for the following

information concerning rules regarding the disposal of surplus narcotics, as they apply when nursing in private homes:

- 1. They should not be destroyed.
- 2. Unless on orders of the doctor, they are not left in the patient's house.
- 3. In the event of the patient's death the nurse gives them to the doctor.
- 4. Acting as agent of the doctor, family or estate, the nurse, when going off duty, returns the drugs to the doctor or the drug store. The drug store, if it has not already done so, may obtain a permit to accept surplus narcotics.
- 5. If, for any reason, the nurse is unable to dispose of narcotics as above instructed, she is advised to contact the local R.C.M.P. office and they will call and collect same.

The Narcotics Division, Department of National Health and Welfare, has approved the publishing of these rules for the benefit of private duty nurses throughout Canada.

British Nurses Relief Fund

The International Council of Nurses has advised the Canadian Nurses Association of the great need for clothing and cash contributions, to assist nurses who are ill, in the following countries in Europe: Holland, Belgium, Denmark, Finland, France, Norway, Russia, Yugoslavia. The Canadian Nurses Association has undertaken to assist the nurses of Holland as far as it has been possible to do so under restrictions imposed by the Wartime Prices and Trade Board. The official request for 25,000 uniforms has not been granted. Permission has been obtained to supply 1,000 used coats and 500 capes. While shoes and stockings are greatly needed, we have not been given permission to secure them.

It is hoped that the provincial asso-

ciations will endeavour, through their provincial British Nurses Relief Fund Committee, to secure the full number of coats and capes required.

Bursaries

The Bursary Award Committee of the Canadian Nurses Association has made the following awards for 1945-46:

Long-Term: (Alberta) Anna M. Conway, Morinville; Dorothy Galloway, Edmonton; Janet G. May, Vancouver; Wilma K. Mc-Cordick, Breton; Janet G. Porteous, Montreal, (British Columbia) Doris L. Brentzen, Duncan; Vancouver: Dorothy E. Gerrard. Edith J. Green, Katherine E. Jones, Hazel Provins; Audrey E. Kay, Essondale; G. Lenore Lamb, Victoria. (Manitoba) Honah H. Card, Winnipeg; Mary T. Mac-Kenzie, Norwood; Mona M. McLeod, Mc-Creary; Verna J. Williams, Selkirk. (New Brunswick) Dorothy D. Parsons, Fredericton. (Nova Scotia) North Sydney: Margaret J. Hartigan, Sister Marion Estelle; Jessie A. McCann, Wallace. (Ontario) Margaret C. Cahoon, Picton; K. Shirley Campbell, Brantford; Lois L. Campbell, Guelph; Gladys E. Hill, Port Arthur; H. Bernice Lewis, Woodstock; Helen H. Littleton, Brampton; Mary A. Munro, Auburn; Margaret L. Peart, Freeman; Lottie Smith, Kingston; Winona Stevenson, London; Sister M. Roberta, Kitchener; Sister St. Cuthbert, Pembroke; Chatham: Violet Gwalchmai, Helen W. Robbins; Hamilton: Ruth E. Aiken, Veronica Swain, Elizabeth Ursulak, Sister M. Paula, Sister M. Rose; Ottawa: Anna M. Beach, Joy K. Clarke; Toronto: Beatrice Ainslie, Dorothy A. Armstrong, Isabel T. Emmerson, Isobel E. Ferguson, Dorothy Loveridge, Doris Muckle, Helen N. O'Rourke, Irene F. Poole, Margaret J. Romano, Margaret E. Sanderson, Margaret J. B. Thompson, Sister M. Evangelista, Sister M. de Sales. (Quebec) Edith M. Gayler, Longueuil; Miriam M. MacLeod, Scotstown; Jean E. MacGregor, Moose Creek, Ont.; Marie-Ange Chamard, Gaspé; Gabrielle Cloutier, St. Hyacinthe; Elizabeth

Quirion, Sherbrooke; Sister Marie Godefroy, Joliette; Sister Marie Victoire, Quebec; Montreal: Denise Richard, Henriette St. Germain, Dorothy L. Ward, Sister Cecile Leclerc. (Saskatchewan) Catherine F. Boyko, Tisdale; Saskatoon: Muriel A. Jarvis. Willa J. Routledge.

Short-Term: (British Columbia) Elizabeta E. Copeland, Vancouver. (Ontario) Edith M. Horton, Ottawa.

Interesting People

After serving as Matron-in-Chief of the Overseas Nursing Service of the Royal Canadian Army Medical Corps since 1942, Lieut.-Col Agnes C. Neill, R.R.C., has returned to Canada to become Matron-in-Chief succeeding Colonel Dorothy I. MacRae, R.R.C. Lieut.-Col. Neill, a native of Ontario, graduated from the school of nursing, Toronto General Hospital. Her executive ability won her immediate headnurseship in the Private Patients' operating room, T.G.H. After a year's post-graduate study at Bedford College, London, Miss Neill returned to her alma mater as surgical supervisor. When war was declared in 1939, Miss Neill enlisted immediately and shortly afterward went overseas as Matron of No. 15 Canadian General Hospital. Her new appointment will provide ample scope for her outstanding administrative abilities.

Lieut.-Col. Neill is admirably suited for the responsibilities to which she has been called. Being a woman of many interests, she has travelled widely, is fond of reading and a game of bridge, and gets full enjoyment out of living. The nurses of Canada are proud to welcome Lieut.-Col. Neill back home and wish her all happiness and success.

Lieut.-Col. Dorothy Riches, R.R.C., has been promoted to be Matron-in-Chief of the R.C.A.M.C. Nursing Service Overseas. A graduate of the University of Saskatchewan and of the school of nursing of the Royal Victoria Hospital, Montreal, Miss Riches is well known to nurses in many parts of Canada. Immediate-

ly upon the completion of her training. Miss Riches went abroad to study nursing conditions in England, Germany and Switzerland. She had served as head nurse on a medical ward at the Royal Victoria Hospital for over two years before she took her post-graduate work in administration and teaching at the McGill School for Graduate Nurses. She was engaged as senior instructor at the Royal Jubilee Hospital, Victoria, when war was declared. In 1941, she enlisted with the R.C.A.M.C. and went overseas as Matron of No. 8 Canadian General Hospital. In 1942, Miss Riches was appointed to the rank of Major (Principal



Ashley & Crippen, Toronto

LIEUT.-COL. A. C. NEILL

Matron) and the following year was posted to the office of A.M.D. 4, Director of Medical Services Branch, Canadian Military Headquarters, London. In the New Year's Honour List in 1944, she was awarded the R.R.C. Her new promotion is well deserved in view of her excellent service overseas.

Ann Peverley has recently been appointed lecturer in public health nursing with the McGill School for Graduate Nurses. Born and educated in Montreal. Miss Peverley graduated from the school of nursing of the Montreal General Hospital. Post-graduate work in tuberculosis nursing at the Royal Edward Laurentian Sanatorium, and in public health nursing at the McGill School for Graduate Nurses, was followed by her appointment to the staff of the Health Department. Westmount, P.Q. At the time of her appointment to McGill University, Miss Peverley was nursing supervisor there. She has taken an active interest in the work of her professional association having been chairman of the provincial pub-



Eugene Suter, Montreal

ANN PEVERLEY

lic health nursing section. At present she is a member of the Board of Managers of the R.N.A.P.Q. Her vivid personality is reflected in her enthusiasm for her new work.

Myrtle I. Graham has returned to the Toronto Western Hospital, where she had served as medical supervisor for four years, as superintendent of nurses. Graduated from the school of nursing of the Winnipeg General Hospital, Miss Graham held her first positions as head nurse, later as medical supervisor in her home school. Post-graduate work in teaching and supervision was taken at the McGill School for Graduate Nurses. In 1940, Miss Graham became assistant director of nurses, later moving up to become director of nurses at the Verdun Protestant Hospital, Verdun, P.Q.

J. Mabel Kniseley has retired from the directorship of the social service (medical) department at the Toronto General Hospital, a position which she has occupied for over twenty-five years. Graduating from the school of nursing of the Toronto General Hospital in 1906, Miss Kniseley has been intimately associated with the growth and expansion of this hospital through the years. After attending the course in social service at the University of Toronto, Miss Kniseley received her appointment and has been instrumental in building the department to its high degree of efficiency. For many years she has received as archivist of her alumnae association. Now, in her retirement, she will be able to devote more time to her favourite hobbies of art and gardening.

Ethel James has recently been appointed as director of nursing of the Saskatoon City Hospital. Miss James graduated from the Royal Alexandra Hospital, Edmonton, in 1930. For the next six years she was employed in general staff nursing at the University of Alberta Hospital, obtaining experience especially in psychiatry and maternity care. After two years in private duty, Miss James re-



Thams Studios, Saskatoon
Ethel James

turned to the "Royal Alex" for experience in the communicable disease hospital. Following her graduation from the course in teaching and supervision at the University of Toronto, Miss James accepted a position as head nurse at the Saskatoon City Hospital. The next year she became nursing arts instructor, moving on to be assistant director of nursing and finally the director. Miss James has served as chairman of the hospital and school of nursing section with the Saskatchewan Registered Nurses Association.

Francine Philo has accepted the position of science instructor with the Regina Grey Nuns' Hospital. Graduating from the school of nursing of this hospital in 1942, Miss Philo has already had a broad experience in a variety of positions. She was one of the early graduates of the newly established course in teaching and



FRANCINE PHILO

supervision at the University of Manitoba. Various forms of needlecraft serve to fill Miss Philo's leisure moments. Another interesting hobby to find in a nurse is a fondness for cooking. Out-of-doors interests centre chiefly around skating.

Recent changes in the nursing staff of the Canadian Red Cross Society in Ontario include the appointment of Muriel Winter as director of the Department of Home Nursing, First Aid and Emergency Reserve in the Toronto Branch. Bertha Miles has been appointed as her assistant. Jessie Goodman, who has been director for over twenty years, has retired. Mrs. George Hanna, who was local officer in charge of the Reserve since it was established, has resigned. Mrs. Donald F. Dewar has been appointed district leader for Central Ontario of the Department of Home Nursing, First Aid and the Reserve.

Obituaries

Lieut. Helen Kathleen Laur, U. S. Army physiotherapist, died in France on July 6, 1945, as the result of an aircraft accident. Lieut. Laur was born in Aylmer, Ont. She was a graduate of the School of Nursing of Victoria Hospital,

London, Ont., and a member of the Class of 1924; she was also a graduate of the Harvard University of Physiotherapy, Cambridge, Mass.

Lieut. Laur had followed her profession in Salt Lake City, Utah, and in Southern California. Four years ago she enlisted in the U. S. Army and served in North Africa and France. It is believed that Lieut. Laur had started on her return trip to America when she was killed. Her tragic death is mourned by her alma mater, Victoria Hospital.

For twenty-five years associated with the Toronto city public health department as a public school nurse, Mrs. Mary Eleanor McConnell died there recently. She retired a year ago. Mrs. McConnell was born in Ireland, received her nurse's training in Scotland, and came to Canada in 1918.

The death occurred recently in Victoria, B.C., of Mrs. Rahno Aitken Walker. Born at Maple, Ontario, she received

her early education in Ontario and attended university in Scotland. She trained at the Toronto General, graduating with the Class of 1903. Following graduation she took charge of the private floors in the Toronto General. Two years later she was appointed superintendent of the Western Hospital, Montreal. After five years in this position she married Dr. Horatio Walker. Following his death. she was appointed superintendent of Good Samaritan Hospital in Los Angeles. During the twenty-five years that Mrs. Walker held the position of superintendent, this hospital developed from 110 to 740 beds and was considered as one of the outstanding hospitals on the Pacific Coast. Mrs. Walker pioneered in introducing an eight-hour day for her staff and students. In 1934 she retired from nursing to locate in Victoria.

Tropical Skin Disease

Seven centres in the United States specializing in the treatment of tropical skin disease will be devoted to the care of men returned from overseas, particularly the Pacific areas. "The new arrangement will make possible better distribution of the limited supply of specialists in dermatology", Major Livingood, consultant in dermatology, said, "and thus give these soldiers the best possible treatment".

There is no basis for fear of tropical skin infections spreading in this country, because practically none of these diseases are contagious and no patient with a transmissible skin disease would be allowed out of an army hospital until he was non-infectious. Acne was given as an example of a common skin disease which flares up in the tropics. One army doctor working on the problem used the word "explosive" in describing the cases he had seen in the Pacific.

"The skin diseases are not fully appreciated by the public in the glare of the more dramatic developments of surgery and problems like malaria", Major Livingood said, "But it is true that in tropical areas about 8 per cent of all army hospital admissions— or one in every 12 or 13— is due to skin conditions".

One of the dermatologist's main efforts is to keep men from "overtreating" skin disease; but the good nutritional state of the American soldier helps protect him from some of the skin diseases common to natives of tropical areas. Major Livingood cited tropical ulcer as an example, saying ulcerations were frequent enough among Americans, but the peculiar tropical ulcer is rare and he thinks that the native gets it because of his poor diet while the American is free of it beacuse he is well ted.

-News Notes, No. 27

Preview

Information about a little known topic will be made available with the publication of F. A. Humphreys' paper on "Tick and Insect Borne Diseases" in our forthcoming issue. Since the infected animals are not restricted to any one area of the country, this new material will be of value and interest to all.

STUDENT NURSES PAGE

Hyperthyroidism

DORIS SWAIN

Student Nurse

School of Nursing, Nicholls Hospital, Peterborough, Ontario.

Mrs. X is a friendly, co-operative person who was born in England and lived there until she was twenty. She is very impulsive and came to Canada without much previous thought as the result of a quarrel. Through an agency she secured a position as housekeeper for a farmer and his elderly parents. After working there for a year she married the son although he was her senior by fifteen years. Mrs. X has two children — a girl of eleven and a boy of nine. Mrs. X's interest has been centred on her children, her husband, and their farm. She has always worked hard, taking a man's place in the fields at harvest time as well as doing all the housework. In fact she has worked so hard at home that her activities and contacts in the community have been slight. The welfare and well-being of the children and her husband have been her primary thoughts. She has given scant attention to her own health until forced to do so through inability to carry on her work.

Mrs. X first found out about her thyroid enlargement when she applied for admission into the nursing school of an English hospital. However, the hospital offered no suggestion for treatment and Mrs. X did nothing further about it. About three months before her admission to hospital, Mrs. X's menstrual periods deviated from normal. They be-

came irregular and she suffered from menorrhagia. She began to lose weight rapidly, experiencing weakness and extreme exhaustion. As she was unable to do her accustomed work she became worried and consulted the local physician who referred her to Dr. Y. He examined her and advised her to come to the hospital to prepare for an operation.

The first noticeable symptoms on admission were her flushed face, prominent eyes, and quick, jerky movements, all typical of hyperthyroidism. Mrs. X had a rapid pulse rate ranging from 100 to 140 beats per minute with good volume. She suffered from shortness of breath necessitating her bed being constantly in semi-Fowler's position. She had an excessive appetite which was appeased only by large, high-caloric meals and frequent lunches. She voided large amounts frequently and had several large bowel movements daily with a definitely foul odour. Dr. Y explained that diarrhea used to be the outstanding symptom of hyperthyroidism and that it was-usually because of this chronic symptom-that the patient consulted a doctor.

The loss of weight experienced by Mrs. X was due to the rapid oxidation of the tissues and the burning up of the body's own tissue protein. Estimation of the basal metabolic rate was, therefore,

a valuable diagnostic measure. Mrs. X had her first basal metabolism test taken immediately; her weight and height were noted and these, together with her age, were given to the doctor. Her basal metabolism was found to be + 45 which is greatly in excess of the normal rate, + 10 to - 10, and indicated a pathological condition.

When Mrs. X had been in hospital about three weeks she suffered from severe epistaxis intermittently for over a week. Her nostrils were packed with absorbent saturated with adrenalin to contract the mucous membrane. Finally the left nostril was cauterized. Vaseline was applied to the nares which were reddened and sore.

A rash appeared on Mrs. X's legs and face and they became swollen. Water drained off soaked oatmeal was applied to the affected areas. The itchiness was somewhat relieved. An accompanying symptom was a temperature elevation of 100°F. to 102°F. After about a week the rash disappeared and the fever abated. This setback was an emotional upset as well as a physical one and the patient was weeks regaining lost ground.

Mrs. X ate heartily and enjoyed her meals. She liked anything and everything, which kept her diet from being a difficult problem. Egg-nogs were her favourite between-meal nourishment. She drank a great deal of water — a pitcher of cold water was kept on her bedside table constantly. She was encouraged to drink water freely because it dilutes the toxins, aids in digestion, absorption, circulation, and excretion; it is also essential in the regulation of body temperature.

Since the metabolism of a hyperthyroid patient is increased 30 much above normal she needed to eat more than usual to maintain and gain body weight. Foodstuffs which strongly activate metabolism are protein, fat, and alcohol. Therefore, these foodstuffs were avoided and the diet consisted largely of carbohydrates.

Phenobarbital was given before each meal because it lessens the metabolic rate, decreases blood pressure, and has a sedative effect. Lugol's solution, containing 5 per cent of iodine dissolved in 10 per cent potassium iodide solution, was given three times a day. It was administered in milk to disguise the unpleasant taste.

If possible Mrs. X was given a full bed bath and change of linen every morning. These had a sedative effect and were necessary from a cleanliness viewpoint because she perspired so freely. Her bed was kept curtained because outside occurrences and other people upset her easily. Her family were the only visitors allowed and their short visits were rare.

In my teaching contacts with her I tried to impress Mrs. X with the value of periodic physical examinations. I talked to her about attempting a more reasonable amount of work. Mrs. X's personal hygiene was good and she needed very little advice on that subject. She was most interested in any information about the children's welfare. I explained the value of inoculations against communicable diseases.

The nursing care study which I made enabled me to give Mrs. X better and more knowledgeable care. In searching for data I acquired facts I had not known regarding hyperthyroidism, nursing technique, and action of various drugs. A study of Mrs. X's background and circumstances showed me the effect these can have on an individual's health.

WANTED

A Matron is required for the Huntingdon County Hospital at a salary of \$115 per month. Room and board provided. Apply to Dr. H. R. Clouston, Huntingdon, Quebec.

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OCTOBER, 1945

Letter to the Editor

By Sailing Ship to Africa

I like ocean travel and look forward to each trip that I take. This time I had a very special reason for looking forward to a month on the water as I was to travel on a sailing vessel, the barkentine, *Tijuca*, a real three-masted merchant ship, and the last of its kind owned by the Argentine Republic.

We sailed from New Orleans on a small Argentine freighter carrying three passengers. After an uneventful three weeks, we arrived in Buenos Aires. B.A., as it is called by those who live there, is the third largest city in the Americas. It is modern in many ways and being developed into a very beautiful city. The Spanish influence is very strong and the official language is Spanish. Fortunately Portuguese and Spanish are very closely allied so that I could make myself understood fairly easily.

There were no sailings to Capetown till January, later till April, later still, July. Was there any chance of getting across to Natal and flying to Leopoldville? The reply came "very little". Finally, rumours flew that the barkentine Tijuca would sail for South Africa on its return from Brazil. Then one glad day, "She is sailing and you are first on the passenger list". That Sunday we watched a tall sailing ship sail into the harbour. Then on Monday we were told, "Passengers must be men only as accommodation is so limited". How could we persuade them to change their minds? Persuade them there was great need for us to get to South Africa. Finally, a friend, unofficial representative of his Exiled European government, was willing to approach the powers that be and present the needs of our African lepers. He persented it effectively because permission was granted.

So we sailed down the River Plate on a three-masted barkentine to sail across the S. Atlantic. The Tijuca was built in England for the French navy in 1868. Napoleon III served aboard her as a cadet; later she served as a cadet ship in the English navy. Then she became a whaling ship sailing down the South Atlantic to South Georgia and across the Antarctic for thirty-seven years. In 1912 she was purchased by an

Argentine company and renamed the Tijuca after a beautiful mountain overlooking the bay of Rio de Janeiro. She has sailed around South America many times and across to Capetown several times in the past few years. On one trip last year she met a bad storm and had her masts blown away. She is 160 feet long, 150 feet from keel to top of masts, and displaces 1,600 tons, small but sturdy.

After sailing downstream we anchored for the night, and waited almost twenty-four hours for wind and tide. Shortly after leaving the river mouth we ran into a bit of a storm in which the passengers got a shaking up. Being on a small boat and a sailing one at that is quite different from a trip on a big passenger ship. Eight of our ten passengers succumbed and the other Canadian and I played stewardess. She is Margaret Dorland Webb, a sixty-year-old "Friend", who is going out with her son and their family to a Congregational mission in southern Rhodesia. The going was rough, but she was a good sport.

Our first Sunday at sea we hit some rough weather and, while I enjoyed it, I wondered how much longer it was going to last and how much rougher it was going to get. We ran out of the storm and had a calm sunset. When there was no wind we could travel at four miles an hour with the aid of a little auxiliary engine, but when we had a wind, we travelled at five, six, seven and up to the fast speed of ten miles an hour! We lay on the deck chairs and relaxed and sun bathed while watching the sails on the tall masts as they flapped in the wind. But some days the wind deserted us completely. One Saturday night there was a fire in the engine room and next day we lay becalmed while they were repairing the engine. While drifting the sailors put out a fishing line to try and catch one of the albatross that had been following us. One beauty got his wing caught in the hook and was dragged up on the deck, a beautiful bird eight and a half feet from wing tip to wing tip, of shining whiteness marked with a few black feathers. After painting two blue rings around his neck, the sailors let him go again. Maybe they will see him the next time they pass that way.



JIMMY: Jeepers, Jerry, Nurses sure bless the "twin benefits" they get from using mild, soothin' Mennen Antiseptic Baby Oil on babies in the hospital and at home!

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NURSE
ADDRESS

OCTOBER, 1945

Again we were on our way. There was a steady right-sided slant just as a yacht slopes to one side with a good wind to drive it along. We rose and fell with the waves, rather than rolled from side to side. On the sailing boat we got what the captain called the "figure of eight motion", a mixture of rise and fall and roll, guaranteed to test your sailing ability. The star-filled sky was very bright at night and the sails were very tall and dark as they were outlined against the Southern Cross. Several times we were driven north out of our course and had to tack due south again towards the pole. One day, looking for a wind to drive us in the right direction, we headed southwest back towards Buenos Aires. Some days the wild beauty of the sea was almost indescribable as one stood by the steering wheel and watched the bow of the boat dip down into the troughs of the waves that broke over it, with a cascade of white foam. Sometimes the waves rose up mountain high on either side as we dipped, with the occasional one coming aboard. One day I started up on deck just in time to have a wave break over the boat and me, incidentally, giving me the only bath I had while on board. I held on and the sea poured on: it was much more satisfactory than our weekly bath in a half pint of water provided by the stewards.

Then came the storm. One afternoon a strong wind blew up and as the captain watched the flaming yellow stin go down he said, "This means a gale", and a gale it proved to be. We settled down for a sleepless night. The waves rose high above the ship on either side. She dipped to the left and the waves came over, then she dipped to the right and received one from the other side, and so the night passed. One of the officers fell out of his bunk twice during the night. The little vessel dipped and rolled, staggered and shook herself free and then the next wave came along. No matter how bad the wave, she always bounded up again.

Boats are beautiful things and sailing ships above all else. I am so glad that I have had the privilege of spending some weeks on one. It will be a memory that will last me to my life's end.

-ANNE E. COPITHORNE

Editor's Note: Miss Copithorne, who is a graduate of the school of nursing of the Vancouver General Hospital, and in public health nursing from the University of British Columbia, has returned to her post in a Leprosarium in Portuguese West Africa after an extended furlough in Canada.

Vitamin C Therapy for Hay Fever now Considered Useless

"About three years ago, the administration of vitamin C was suggested for the treatment of hay fever and other allergic conditions," the Journal of the American Medical Association said. Generally this therapy has been viewed with scepticism, but nevertheless some have given it fair trial. Most recent of the reports is that of Sidney Friedlaender and S. M. Feinberg, who found that hay

fever patients have a normal level of vita-

Although large doses of this vitamin produce saturation blood levels, they do not change the course of hay fever or asthma. In view of this and previously published evidence, vitamin C therapy for hay fever and other allergic conditions may be considered useless and wasteful.

Anti-Malaria Program in Greece

The largest air-borne anti-malaria program yet launched in Europe will soon be undertaken by UNRRA in Greece in co-operation with the Greek Government. As part of an all-out drive against the critical increase of malaria in Greece, UNRRA is sending ten specially equipped planes to that

country to be used in spraying mosquito breeding areas with DDT.

According to the UNRRA Chief Medical Officer in Greece, Dr. J. Balfour Kirk, there are some areas in the country where 100 per cent of the population is infected with malaria fever. Data now available in-



OCTOBER, 1945



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PALMOLIVE

dicate that 40 to 50 per cent of the country will be infected during the season which lasts from April through October. The present number of victims approaches the three million mark. Prior to the war, the estimated average number of cases in Greece was approximately fifty thousand per year.

Destruction of supplies and facilities by the Nazis, disrupting anti-malaria services during the war, is the direct cause of this situation. Another factor contributing to the spread of the disease is the general lack of food. People suffering from malnutrition fall easy victim to the disease.

For the purpose of conducting the Greek anti-malaria campaign, the country has been responds to the drainage of one of the ten divided into ten regions. Each region cormajor rivers in the country. An UNRRA plane will be assigned to each region. Of the total of one million acres of malaria-breeding territory in the country, approximately three-fourths, or 750,000 acres, will be sprayed with DDT by plane. It will be necessary to treat the remaining acreage by standard methods because of the terrain or other factors which make aerial treatment impractical.

In spraying the swamps, the planes will fly only five to ten feet above the surface and will cover 17 acres per minute. Each plane will carry a load of 33 gallons of DDT solution. The solution developed for the purpose is 20 per cent DDT mixed with a naphthalin solvent, and will kill both adult mosquitos and larvae. It is turned into spray by a special generator and discharged through the motor exhaust. Sixty-five hundred gallons of solution will be shipped to Greece with the fi st four planes; an amount sufficient to cover approximately 100,000 acres of mosquito-breeding swamp land. This amount is in addition to the 40,000 pounds of 100 per cent DDT and the 120,000 pounds of 10 per cent DDT which have already been shipped.

In addition to the planes and other equipment necessary for the treatment of malaria swamps, UNRRA, will aid health officials in the work of spraying 750,000 homes with DDT. Up to the present time, UNRRA has shipped to Greece 28.000.000 tablets of atabrine and 150 kilograms of quinine. These drugs are sufficient to provide treatment for approximately 2,500,000 malaria victims.

-UNRRA News.

R.C.A.M.C. Nursing Service

Lieut. Col. Agnes C. Neill, R.R.C., Matron-in-Chief, R.C.A.M.C. Nursing Service Overseas, has returned from England to become Matron-in-Chief of the Nursing Service in Canada, replacing Col. Dorothy I. MacRae, R.R.C., who is retiring from the Service and is at present taking a course in hospital administration at the McGill School for Graduate Nurses.

Major (P/M) Dorothy M. Riches, R.R.C. (Royal Victoria Hospital, Montreal), has been appointed Matron-in-Chief of the Nursing Service Overseas and has been promoted to the rank of Lieut. Col.

Major (P/M) Agnes J. Macleod, R.R.C., (Alberta University School of Nursing) has retired from the Service and has been appointed Matron-in-Chief, Department of Veterans Affairs.

Capt. (Matron) Dorothy M. Percy (Toronto General Hospital) has retired from the Service and is now secretary of the Health Division, United Welfare Chest. Capt. (Matron) Ella G. Covey (Toronto General Hospital) has been appointed Matron of Petawawa Military Hospital and has been replaced on the hospital ship Lady Nelson by Major (P/M) Sarah Miles (Royal Victoria Hospital, Montreal) who recently returned from overseas. Capt. (Matron) Margaret Kellough (Toronto General Hospital) has been posted as Matron of Malton Convalescent Hospital.

The following have been awarded the R.R.C.: Major (P/M) Doris Kent (Toronto Western Hospital); Mary' Mills (Vancouver General Hospital); Jean Nelson (Victoria General Hospital, Halifax); Elsie L. Riach (Regina General Hospital); Capt. (Matron) Mary B. MacNcill (St. Joseph's Hospital, Glace Bay); A/Capt. (Matron) Atala Coloumbe (St. Sacrement Hospital, Quebec).

The following have been awarded the A.R.R.C.: Lieut. (N/S) Freda Bossy (Royal Victoria Hospital, Montreal); Valerie Hora (Kingston General Hospital); Mary Loggin (University of Alberta Hospital); Hilda I. Morrill (A. J. Hospital training school, Newburyport, Mass.); Dorothy E. Murphy (Montreal General Hospital); Denise A. Rastoul (Notre Dame Hospital, Montreal); Ruby Rogers (Toronto General

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OCTOBER, 1945

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Hospital); Jeanette B. Rusenel (Children's Hospital, Winnipeg); Florence B. Balcom (Toronto General Hospital).

The following have been mentioned in Despatches: Capt. (Matron) Rita Ackhurst (Royal Victoria Hospital, Montreal); Lieut. (N/S) L. E. Bibby (Hotel Dieu Hospital, Kingston); M. F. Cascaden (Brandon Gen-

eral Hospital); Anne Halabuza (Grey Nuns' Hospital, Regina); Mary M. Mac-Donald (Misericordia Hospital, Edmonton); Madeline Taylor (Montreal General Hospital); Velma G. MacKenzie (Brockville General Hsopital); Dorothy M. Knight (Victoria Hospital, London, Ont.); Frances J. Tomkins (Victoria Hospital, Winnipeg).

Ontario Public Health Nursing Service

Edith Thompson (Toronto General Hospital and University of Toronto public health course) has resigned her position with the Kingston Board of Health.

Helen Etherington (St. Catharines General Hospital and University of Toronto public health course) has resigned her position with the International Nickel Company at Copper Cliff to accept an appointment with the B. C. Department of Health.

Helen Carpenter, B.S., M.P.H. (School of Nursing, University of Toronto diploma course; Bachelor of Science, Teachers Col-

lege, Columbia University; Master of Public Health, Johns Hopkins University) has been appointed supervisor of nurses, East York Health Department.

Louise Grover (Toronto General Hospital and University of Toronto public health course) and Nora Kenny (Guelph Generalr Red Cross to accept an appointment with the Markham Township Board of Health.

Isabelle Lucas (Grant Macdonald Training School, Toronto, and McGill University) has accepted a position with the Kirkland-Larder Lake Health Unit.

Anne Jack (Hamilton General Hospital and University of Toronto public health course) and Nora Kenny (Guelph General Hospital and University of Toronto public health course), formerly nursing sisters with the R.C.A.M.C., have joined the staff of the Welland-Crowland Health Unit.

Mary Mason (Toronto General Hospital and University of Toronto public health course) and Nora Kenny (Guelph General R.C.A.M.C., has accepted a position with the Northumberland and Durham Counties Health Unit.

Irene Martin (Hotel Dieu, Cornwall, and McGill University) and Norma Tonkin (Toronto Western Hospital and University of Toronto public health course) have accepted positions with the Stormont, Dundas and Glengarry Health Unit.

Norah Cunningham, B.A.Sc. (Vancouver General Hospital and University of B.C.) has resigned from the St. Thomas Board of Health to accept the position of senior nurse with Haldimand County School Health Service.

The following graduates of the public health nursing course at the University of Toronto have accepted appointments: Gladys Aylsworth (Toronto General Hospital) and Gwenyth Waller (Hamilton General Hospital) with the Northumberland and Durham Health Unit: Hilda Vohman (Grace Hospital, Toronto) with the St. Catharines-Lincoln County Health Unit; Margaret Goodes (Hamilton General Hospital) and Jean Scrimgoeur (Toronto General Hospital), formerly nursing sister, R.C.A.M.C., with the St. Catharines-Lincoln County Health Unit; Mrs. Peter B. (McIVilliams) Reid (Brantford General Hospital) with the Picton Board of Health.

The following graduates of the public health nursing course at the University of Western Ontario have accepted appiontments: Ruth Burney (Victoria Hospital, London) with Forest and Sarnia Township; Patricia Bourke (St. Joseph's Hospital, London) with the Kirkland-Larder Lake Health Unit: Marguerite Langdon (Stratford General Hospital) with the Northumberland and Durham Health Unit; Janet Folster (Hospital for Sick Children, Toronto) and Dorothy Stone (Brantford General Hospital) with the Oxford County Health Unit; Ellen Holland (Victoria Hospital, London) with York Township,





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For information apply to:

School for Graduate Nurses, McGill University, Montreal 2

Relapsing Fever

The extensive epidemics of typhus which swept North Africa during the war have been followed by an epidemic of louse-borne relapsing fever. This is stated by Dr. G. Stuart, Chief of the Epidemic Control Section of the UNRRA European Regional Office, UNRRA Epidemiological Information Bulletin No. 11. More than forty thousand cases were reported up to March, 1945, mainly in Tunisia, but in recent months the outbreak has spread also to Algeria and Moroco-

After World War I, Eastern Europe suffered from extensive epidemics of relapsing fever, and some twenty years ago this disease decimated the population of the semi-arid country south of the North African desert belt. Lately, there have been small outbreaks in southern France and in Rumania, but, so far, there has been no major epidemic in Europe.

Several hundreds of typhus cases have been found among the displaced persons returned from Germany to their native countries.

Cholera appears to be more widespread than usual in China, India and French Indo-China. By the end of June there were eight thousand cases in Chungking. Since 1921, cholera has remained confined to Asia, and, so far, no case has appeared west of Bombay.

Epidemic Diseases in China

Detailed information regarding the prevalence of epidemic diseases in China became available recently for the first time in history. In spite of immense difficulties arising from the war, the Chinese Health Administration increased the number of hsien (county) health centres from 220 in 1937 to 895 in 1943, thus covering 66 per cent





can be used and recommended whenever mild laxative and gastric antacid action are indicated as in colds, peptic ulcer, hyperacidity, etc.

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WINDSOR, ONTARIO

of the hsiens in unoccupied China. Although returns from these health centres represent only a fraction of the cases of epidemic diseases occurring in China, these data suffice to show the trend and geographical distribution of the major diseases.

According to Dr. J. H. Fan, technical expert at the National Health Administration of China, bubonic plague has spread inland during the war from the coast provinces, where the incidence is greatest, but the provinces around Chungking have not so far been reached. There is another plague centre in Yunnan, which includes localities on the Burma Road, and one in the northwestern provinces. The spread of plagueinfected rats was facilitated by primitive methods of transportation of rice resorted to en account of Japanese occupation of ports and railroads. There is some evidence that plague-infected fleas may, on two occasions, have been spread by Japanese planes, but it seems that this alleged attempt of bacterial warfare has been only experimental. At any rate, it has had little importance in comparison with the general spread of the disease.

Under present conditions cholera is perhaps the most feared epidemic disease although in the long run bacillary dysentery causes more deaths and is said to kill more people in China than any other single disease except tuberculosis. Cholera was widespread in 1939 and 1942, and is now once more ravaging the inland provinces, including the province of Szechwan in which Chungking is located. Like dysentery, cholera is most prevalent in southern China.

China has also experienced a marked increase of louse-borne typhus and relapsing fever during the war. These diseases are most prevalent in northern China, but the incidence is high also in the southern provinces of Yunnan and Kwichow where fleaborne typhus also is common. The incidence of relapsing fever has increased steadily during the last five years and is now greater than that of typhus. Typhoid fever and smallpox are of common occurrence, but their incidence is apparently not equal to that of dysentery and cholera.

A tremendous task of combatting epidemic disease in China lies ahead, now the war is over, but the rapid extension of Chinese preventive action under most trying conditions augurs well for the future.

-UNRRA News.

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"Nurses on the Home Front"

An exceedingly interesting sketch dramatizing the close co-operation which is possible between the nurses in industry, in hospital, and those doing the visiting in the homes was written by Sister Margaret Mooney, R.H., R.N. Sponsored by the Cornwall Chapter of the Registered Nurses Association of Ontario this playlet aroused considerable interest.

The story centres around the problems which arose in a family when the father received very severe burns in a war-plant necessitating hospitalization. How the wife and children were assisted in their adjustments to this situation, how their morale was boosted by the visits of the nurse is depicted with a sure and humorous touch. Sister Mooney's sketch would provide entertainment for other chapters. Write to her at Hotel Dieu Hospital, Cornwall, if you would like to produce this little play.

Book Reviews

Introduction to Public Health, by Harry S. Mustard, M.D. 259 pages. Published by The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 2nd Ed. 1945. Price \$3.50.

Reviewed by Kate M. McIlraith, District Superintendent, Ottawa Branch, Victorian Order of Nurses for Canada.

"Introduction to Public Health" is a book which might well be used, not only as a reference for public health nurses, but as a textbook for student nurses in the training school. It should prove invaluable to integrate the social health aspects of nursing in the basic course.

The author deals with the various subjects—obstetrics, pediatrics, communicable diseases, tuberculosis—to mention a few, and at the end of the chapters dealing with each subject he summarizes and lists the public health aspects. Thus, in the student's course, she

could learn to see beyond the care of the patient in the hospital to the community outside and to realize the importance of preventive, as well as curative nursing and the part that she might play in bringing about a realization of the importance of health. It would help her to see the hospital as just one of several community agencies working for the welfare of the patient, rather than as an isolated and complete unit.

Today instructors are seizing every opportunity to emphasize the preventive health and social aspects of nursing from the time the student enters the school of nursing until the completion of her nursing program, and the regular and constant use of this book should prove of inestimable value.

The March of Medicine in Western Ontario, by Edwin Seaborn, M.D., F.A. C.S., Ll.D. 378 pages. Published by The Ryerson Press, 299 Queen St., W., Toronto 2 B. 1st Ed. 1944. Illustrated. Price \$6.00.

For those who are interested in the life histories of the men who formed the vanguard of the medical profession, particularly in Western Ontario during the nineteenth century, this book presents a very wide range of biographical outlines. There is much human interest in the rambling accounts of the early medical pioneers. At times, the "march" becomes wearisome through over-emphasis on irrelevant data regarding who was married to whom, the lists of their progeny and similar non-essential information. As a source of this type of vital statistics, the book will doubtless hold interest for those who are more familiar with that geographical area. The tedium is relieved, however, by the descriptions of the difficulties under which this intrepid group worked, of the struggles they had to bring medical care to those in need, by the picture of primitive conditions under which they performed operations. Quite an insight may be gained into the catastrophe of cholera epidemics. Excellent line drawings of many of the personages adds greatly to the interest.



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Miss F. Munroe, R. N., Superintendent of Nurses, Royal Victoria Hospital, Montreal, P. Q.

REGISTERED NURSES' ASSOCIATION OF BRITISH COLUMBIA

Placement Service

Information regarding positions for Registered Nurses in the Province of British Columbia may be obtained by writing to:

Elizabeth Braund, R.N., Director
Placement Service

1001 Vancouver Block, Vancouver, B. C. The Psychology of Insanity, by Bernard Hart, M.D., F.R.C.P. (Lon.). 172 pages. Published by the Cambridge University Press, England.

First published in 1912, this admirable analysis of the psychological factors inherent in insanity remains an absorbing book. The fourth edition presents no material alterations in the original text indicating the precision and clarity with which Dr. Hart originally surveyed this engrossing subject. With numerous illustrative examples he proceeds with the elucidation of the individual symptoms which are presented, showing the relationship of each to the total picture of the disturbed mind. He uses the scientific approach in proving that a vast proportion of the cases which crowd our mental hospitals result from a conflict between the great primary instincts and the standards and mores the "herd instinct" decrees. Nurses will find the material clear and direct, a ready means of interpreting the queer foibles of which we are all guilty at one time or another, and an aid in understanding some of the eccentricities of their patients.

NEWS NOTES

ALBERTA

RED DEER:

The following officers were recently elected by District 6, A.A.R.N.: chairman, Mrs. Bernice Legge; vice-chairman, Betty Manning; secretary-treasurer, Martha Smith.

At a recent meeting, with about twenty present, the members heard an interesting talg by Dr. G. R. Hancock on "Penicillin and its Use". The association decided to invest in a \$50 Victory Bond. At a later gathering in the summer Betty Manning reported on the meetings she had attended in Edmonton to discuss a Nurses Placement Bureau. Martha Smith was appointed as the district representative to the Labour Relations Committee for the province and Miss Manning as representative to the Provincial Placement Bureau.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Gena Bamforth, 54 The Oaks, Bain Ave., Toronto 6.

DISTRICT 1

A regular meeting of District 1, R.N.A.O., was recently held at the Sarnia General Hospital, with the chairman, May Jones, presiding. The guest speaker, Dr. J. Roberts, Sarnia, gave a most interesting address on "Modern Trends in Surgery".

The highlight of the business meeting

was the appointment of a committee to study the standardization of nursing procedures in the District, with Rahno Beamish as chairman. Representatives from Chatham, London and Windsor will be chosen to serve on this committee. May Jones gave a report of the R.N.A.O. annual meeting. Reports from the various sections were also read and adopted.

The following officers were elected due to resignations: secretary-treasurer, Laura Johnston, Memorial Hospital, St. Thomas; Windsor councillor, Mabel Sharpe, Essex County Sanatorium.

DISTRICT 6

The semi-annual meeting of District 6, R.N.A.O., took place recently at the Ontario Hospital, Cobourg, with the chairman, Mrs. E. Brackenridge, presiding. Interesting reports from chapters, sections, and committees were given. The chapters, reporting on monthly meetings, social activities, and the memorial service for nurses, showed increased interest. Of special interest in the hospital and school of nursing report was the appointment of a part-time social director for the recreational activities of the student nurses at the Nicholls Hospital; the erection of a nurses residence at St. Joseph's Hospital, Peterborough; post-graduate courses for the instructor, operating room and ob-stetrical supervisors of the Ross Memorial Hospital, Lindsay.

Fifty members and guests were entertained at a banquet. Miss Polson, chairman of Chapter B (Cobourg and Port Hope) welcomed nurses and guests in the evening when they were privileged to hear Dr. A. R. Montgomery, director of hospital services, speak on "Psychiatry in Relation to Nurse Education". Interesting points were expressed by the speaker to an audience of about two hundred and fifty.



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DISTRICT 7

Dorothy Riddell, Inspector of Training Schools for Nurses, met recently in a conference with the training school officials and supervisors of the Ontario Hospital, Kingson, to discuss the curriculum for the proposed affiliation in psychiatry for the student nurses from the general hospitals in Eastern Ontario.

The following day the superintendents of nurses from these hospitals, with Miss Riddell, Dr. J. S. Stewart, medical superintendent, E. G. Smith, superintendent of nurses and instructresses from the school of nursing, discussed more fully the plans for this affiliation. Dr. C. H. McCuaig, professor of psychiatry, Queen's University and assistant superintendent of the Ontario Hospital, was also present to offer advice.

The course will consist of psychiatry, 12 hrs., mental hygiene — general and childhood, 15 hrs., psychiatric nursing, 15 hrs., hydrotherapy, 4 hrs., occupational therapytheory and laboratory, 9 hrs., neurophysiology and endocrinology, 10 hrs. Bedside ckinics, ward clinics, morning circles and seminars will be conducted during the course.

SASKATCHEWAN

Moose Jaw Chapter:

Rev. Sr. M. Modesta, Providence Hospital, and S. Hagan, General Hospital, have recently completed their courses in teaching and supervision at McGill University. C. Lennie and J. Cowan have completed courses in teaching and supervision at the University of Manitoba. J. Heighton and J. Purdy are planning to study public health at the same university this coming year. A. Skaftfeld has returned from the University of Toronto where she took the teaching and supervision course. K. Jamieson is with the Department of Public Health in charge of the new V.D. clinic at the Moose Jaw General Hospital.

HUMBOLT:

The seventh annual reunion of the St. Elizabeth's Hospital Alumnae Association was recently held when the register was signed by twenty-one graduates ranging from 1926 to 1945. Among those returning for the reunion was N/S Caroline Dauk who recently arrived from overseas after seeing service in England, France, Belgium, Holland and Germany. The enjoyable reunion was brought to a close with a wiener roast and sing-song.



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SASKATOON:

City Hospital:

M. Ballard has been appointed assistant director of nursing. Miss Ballard served with he R.C.A.M.C. for two years in Canada and for twenty-two months in Italy, Sicily, Belgium and Holland.

The following members of the nursing staff of the City Hospital are leaving to take post-graduate courses: M. Jarvis, who has been assistant director of nursing, administration in schools of nursing, McGill University; W. Routledge and G. Laing, teaching and supervision, University of B.C.; F. Odegard, operating room technique, Vancouver General Hospital.

St. Paul's Hospital:

Martha Samletzki, who has been with the Public Health Department as district nurse at Herbert, left recently for the University of St. Louis. This university grants a number of fellowships each year to promising graduates who wish to take advanced work in teaching and supervision or public health. Miss Samletzki has been chosen by her school of nursing as worthy of this opportunity.

REGISTRATION OF NURSES Province of Ontario

EXAMINATION ANNOUNCEMENT

An examination for the Registration of Nurses in the Province of Ontario will be held on November 21, 22, and 23.

Application forms, information regarding subjects of examination and general information relating thereto, may be had upon written application to:

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WANTED

Vancouver General Hospital desires applications from Registered Nurses for General Duty. State in first letter date of graduation, experience, references, etc., and when services would be available.

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Miss E. M. Palliser, Director of Nurses, Vancouver General Hospital Vancouver, B. C.

WANTED

General Duty Nurses, registered or graduates, are required for the Lady Minto Hospital. The salary is \$90 and \$80 per month, with full maintenance. Apply, stating full particulars of qualifications, to:

Lady Minto Hospital, Cochrane, Ont.

WANTED

Applications are invited for the positions of a qualified X-Ray Technician and a Dietitian. Apply, stating qualifications and salary expected, to:

Sister Superior, Holy Family Hospital, Prince Albert, Sask.

WANTED

Applications are invited for the position of Superintendent of Nurses in an 80-bed hospital in Southern Ontario. Apply in care of:

Box 8, The Canadian Nurse, 522 Medical Arts Bldg., Montreal 25, P. Q.

WANTED

A Dietitian and a Supervisor for a Tuberculosis Annex are required immediately for the Highland View Hospital, Amherst. Apply, stating qualifications, to:

Business Manager, Highland View Hospital, Amherst, N. S.

WANTED

Applications are invited for the position of a qualified Operating Room Supervisor. Salary, \$105 per month. An experienced X-Ray Technician is also required. Apply, stating qualifications, age, religion, etc., to:

Superintendent, Glace Bay General Hospital, Glace Bay, N. S.

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A qualified Instructress is required immediately for the Portage la Prairie General Hospital. Apply, stating qualifications, experience, and salary expected, to:

Superintendent, Portage la Prairie General Hospital, Portage la Prairie, Man.

WANTED

Applications are invited immediately for Staff positions with the Department of Public Health & Welfare, Halifax. Salary: Registered Nurses with public health course, \$1500-\$1800; Registered Nurses without public health course. \$1320-\$1440. Uniforms, cost of living bonus, etc. provided. Apply, stating qualifications, age, etc., to:

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The Superintendent, Stratford General Hospital, Stratford, Ont.

WANTED

A qualified Assistant Instructress is required immediately for a 135-bed hospital. Apply, stating qualifications, experience, and salary expected, to:

Superintendent of Nurses, Royal Inland Hospital, Kamloops, B. C.

WANTED

Two Supervisors, with experience in Tuberculosis work, are required for the Nova Scotia Sanatorium, Kentville, N. S. Apply, stating particulars and qualifications, to:

Nova Scotia Civil Service Commission, Box 943, Halifax, N. S.

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A qualified Instructress is required immediately for the Sherbrooke Hospital. Apply, stating qualifications, experience, and salary expected, to:

Superintendent of Nurses, Sherbrooke Hospital, Sherbrooke, P. Q.

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WANTED

Two Registered Nurses are required for General Duty. The salary is \$100 per month, plus maintenance. Apply to:

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OCTOBER, 1945

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Prince Edward Island Registered Nurses Ass'n: Miss Helen Arsenault, Provincial Sanatorium, Charlottetown.

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NOVEMBER 1 9 4 5 THE

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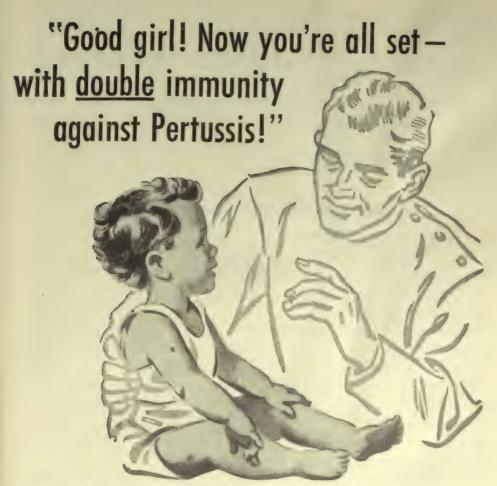
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Vol. 41, No. 11 838

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In 1850 the ship "Norman Morrison" arrived in Esquimalt Harbour bringing a number of pioneer immigrants. Smallpox had broken out during the voyage but so skilfully did the young surgeon, John Sebastian Helmcken, treat his patients that the epidemic was halted and few casualties resulted. For his friendly, generous and humorous nature Helmcken soon was beloved by all in the new colony. He distinguished himself in his profession, both in his private practice and as Coroner and Health Officer. He was appointed first president of the British Columbia Medical Association in 1885. At the same meeting his son, Dr. James Douglas Helmcken, was elected secretary-treasurer. He was active in the provincial government, representing Esquimalt in the first House Assembly of Vancouver Island. After Confederation he was offered a Senatorship but declined, preferring to continue his medical practice.

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NOVEMBER, 1945 830

Reader's Guide

Jean Isabel Masten, our guest editor this month, has had an interesting career. Years before she received her nurse's training at the Hospital for Sick Children in Toronto, she took a fifteenmonths course in massage and remedial gymnastics at Guy's Hospital, London, Following her graduation in nursing Miss Masten served successively as director of physiotherapy and in various departments in her own and the Toronto General Hospital. In 1934-35 she took the course in teaching and hospital administration offered in London under the auspices of the Florence Nightingale International Foundation. Since 1939 she has been superintendent of nurses at the Hospital for Sick Children. As president of the Registered Nurses Association of Ontario Miss Masten guides the destinies of the largest provincial nurses' association in Canada with thoughtful graciousness.

We have been honoured twice in one year by receiving valuable articles from the pen of Dr. S. R. Laycock, of the Department of Education, University of Saskatchewan. As well as being an exceedingly well-informed, versatile lecturer and radio speaker on the behaviour problems and kindred aspects of mental health, Dr. Laycock is a fluent writer. His suggestions contained in the current article should receive careful consideration. Sooner or later each of us will be in the category of "the older nurse".

Dr. F. A. Humphreys is a bacteriologist with the Laboratory of Hygiene (Western Branch), Department of National Health and Welfare, stationed at Kamloops, B.C. This fine condensation of his address given at the annual meeting of the Kamloops-Okanagan District, R.N.A.B.C., was prepared by Jean Phillips.

Mrs. H. Aline Paice is a nurse who has spent the greater part of her professional career as a medical social worker. She is director of this department at the Royal Victoria Hospital in Montreal. Mrs. Paice seeks to interpret medical social work to nurses to bring about greater mutual understanding with greater resultant service to the patients.

Edith Buchanan has only recently returned to her post in the school of nursing administration, Lady Reading Health School, Delhi, India, after spending a year at the University of Toronto School of Nursing. Her story of prewar life and nursing conditions in India makes fascinating reading. Next month we will present the second part of her story—the account of present-day problems in nursing in an awakening India.

Isobel Black, B.Sc., is instructor in public health nursing at the University of Manitoba. Her interest in and familiarity with family health counselling can be traced back to her years of experience with the Victorian Order of Nurses in various parts of Canada. Her review of the excellent refresher course held in Winnipeg contains many useful suggestions for public health nurses.

Catherine O'Hanley is a private duty nurse in Charlottetown, P.E.I.

Our cover pictures, both last month and this, were taken by a skilled amateur photographer, Ralph Higginson of Montreal. Though we only need twelve pictures a year, it is surprisingly difficult to secure suitable prints. Interesting shots of nursing procedures are always welcomed. What have you to offer?

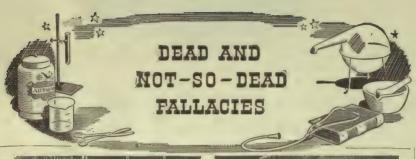


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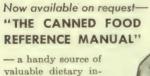


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REFERENCES: 1. West. J. Surg. & Gyn., 51:150, April, 1943. 2. Clin. Med. & Surg., 46:327, August, 1939. 3. Am J. Obst. & Gynec., 46:259, 1943.

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*Santon Gilmour. (1937) Tubercle, vol. 19, p. 105.

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The CANADIAN NURSE

A MONTHLY JOUR NAL FOR THE NURSES OF CANADA PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-ONE

NUMBER ELEVEN

NOVEMBER 1945

Unity, Understanding and Co-operation

The strains of war have revealed strengths and weaknesses, which were but imperfectly recognized, in organized nursing. This presents the profession with a challenge and an opportunity in the immediate post-war years. Our profession is young and we are yet groping for a pattern of internal organization and of relationships. Much depends on our wisdom and our breadth of vision as we decide the nursing trends of the future.

During the past war years issues of provincial, dominion and international significance assumed greater urgency) than ever before. This occurred at a time when each member felt engulfed by her own local responsibilities. Fortunately the Canadian Nurses Association, with the assistance of the federal government grant, was able to expand its activities and has been of very great assistance in meeting the military and civilian responsibilities with which we, as a profession, were confronted.

In the political sphere Dominion-Provincial relationships constitute one of





JEAN I. MASTEN

NOVEMBER, 1945

the most important problems of the day for Canadians. It is very essential that in the smaller sphere of nursing we establish these relationships upon firm foundations. As in the political sphere, each provincial registered nurses association has its own peculiar problems, some of which depend on the political set-up in the particular province, but most assuredly each association should look to the national association for overall guidance and for the most essential co-ordination of all provincial nursing activities. Out of the Dominion-Provincial conferences will doubtless come principles and policies applicable to organizations such as our national and provincial nursing associations.

One of the greatest problems of the Registered Nurses Association of Ontario is to reach every nurse in our large province, gain her interest and support and keep her informed of nursing affairs. The war has shown us that, even in an age providing rapid and reliable air mail facilities, the real decisions were all made during personal conferences. Our immediate intention is to have a member of the provincial office staff go to the ten districts of the province, with time for contacts wider than can be obtained in formal meetings. It will be her aim to discover how the association can best serve its members and to disseminate fuller information than can be imparted in minutes and circulars.

The future holds great possibilities for this most essential of professions. Much change and evolution are inevitable. The nursing profession in Canada will make its best contribution if we preserve the fullest degree of unity, understanding and co-operation in our interprovincial and our national relationships.

JEAN I. MASTEN
President
Registered Nurses Association of
Ontario.

Registered Nurses' Identification

When the public see a nurse wearing dull cherry epaulettes with diamond-shaped pieces of green cloth affixed to them, they will know that she is registered as a medical and surgical nurse, and as a midwife. South Africans will soon be able to identify classes of nurses by their epaulettes and "pips".

Hitherto registered nurses have worn a metal badge on the breast which, however, has been optional. The newly-created S. A. Nursing Council has made regulations — approved by the Minister of Welfare and Demobilization, Mr. H. G. Lawrence — making it compulsory for persons registered under the Nursing Act to wear distinguishing badges when on duty.

The following are the colours of the epaulettes to be worn by the various classes:

Medical and surgical nurses, dull cherry; male nurses, brown; mental nurses, dark saxe blue; nurses for mental defectives, light saxe blue; fever nurses, yellow; midwives, green. Diamond-shaped pieces of cloth on the epaulettes will indicate whether a nurse is registered in two or more classes, or as a midwife in one or more classes.

A nurse's "pips" will be the Nursing Council's new badge, which will be embroidered in gold-coloured thread near the shoulder edge of the epaulette. The design of the badge is a "Florence Nightingale" lamp over two protea branches, which provide a South African background. It is ringed by the words "S. A. Nursing Council" and "S.A. Verpleegstersraad".

-The South African Nursing Journal.

The Adjustments of the Older Nurse

S. R. LAYCOCK

A great deal of attention is now being given to both the physical and the mental hygiene of later life. The study of our older citizens is being carried on vigorously by medical men, psychologists, sociologists, and others. Indeed, in the field of medicine, an entirely new branch of study has grown up - geriatrics, the study of the aged. Psychologists, too, have been studying the problem of the aging of the various human abilities, as well as the extent of the possibilities of learning by older folk. The mental hygienist also has turned his attention to the adjustments of those in later life. Then, too, educators who are interested in adult education and vocational guidance have suddenly become aware of new possibilities for their efforts among those who have advanced to the last two or three decades of life.

The problem of the older nurse is one which gives considerable cause for concern to the leaders of the nursing profession. This problem has two aspects — the economic and the psychological.

ECONOMIC PROBLEMS OF OLDER NURSES

The economic problem of older nursses is particularly acute in the case of private duty nurses, particularly in regard to provision for their old age. Nurses employed by governments and other public bodies often come under a civil service or other pension scheme. With them, therefore, the spectre of what will happen to them after retirement does not stalk abroad as is the case with private duty nurses. The latter often find it impossible to save sufficient money even to make a beginning of providing

for their old age. This fact is apt to cause them to feel not only financially insecure, but also to feel emotionally insecure. "Freedom from Want," it must be remembered, is basic to "Freedom from Fear." Fear caused by the prospect of economic insecurity in the event of illness, accident or retirement is apt to haunt the minds of nurses over forty years of age, and to greatly decrease both their efficiency and their happiness. There would seem to be only two possible solutions for the economic insecurity of nurses. One would be a change in the status of the nursing profession so that, like school teachers, they would be employed by public bodies and come under provincial pension schemes. The other would be a change in the social policy of the nation as a whole whereby all elder citizens would, on retirement, receive an adequate pension.

PSYCHOLOGICAL PROBLEMS OF THE OLDER NURSE

Nurses are as human as other people. They, too, have the basic psychologic al needs for affection and belonging, independence, achievement, recognition and a sense of personal worth. As they pass the age of forty or forty-five, their concern over the adequate meeting of these needs is apt to be increased.

First of all, nurses, like other people, need to love and be loved, and to feel that they belong to family, friendship and community groups. As they grow older, ties with their own immediate families are apt to weaken. Their parents pass on, and their married brothers and sisters have families and interests of their own. Because of the very nature of the hours at which they work the

social life of many nurses is apt to be interfered with. It is very easy for an older nurse to find that she has no close friends of her own age, especially among married folk. Actually she needs such associations desperately. It is not just a matter of loneliness. Lack of emotional security which often causes delinguency in children is apt to cause symptoms of "old maidishness" among many older nurses. These symptoms may express themselves in bossiness and overefficiency, gushiness, prudishness or cattiness. When they occur they make a happy adjustment and reasonable efficiency much more difficult.

Secondly, nurses, like other folk, need to feel that they have reasonable freedom in managing their own lives and making their own decisions. Too often, in middle life, nurses come to feel that they are in a treadmill from which they cannot escape. If they are private duty nurses they may feel that they are condemned to the same locality, to the same job and to the same pay for the rest of their lives. Certainly, the fear of becoming economically dependent after their retirement, which was described above, lessens the satisfaction of their present independence. If, on their retirement, they have to go and live with married relatives and be dependent on them, more or less acute unhappiness is nearly bound to result.

In the third place, nurses, like all human beings, have needs for achievement, recognition and self-esteem. They need to obtain joy and satisfaction from the work they do and to feel that they get public recognition for it. They need the approval of their own consciences, and to feel that they are worthwhile persons. If they have chosen their profession wisely and have kept up-to-date professionally, they can find fulfilment for these needs so long as they are able to work. But when they retire, what then? Here the public health nurse may be in an even worse position than the private

duty one. She is retired at a definite age no matter how effective and vigorous she may be. She has taken away from her what Dorothy Canfield Fisher calls "the vitamin of WORK". Certainly mental hygienists are agreed that, for mental health, a reasonable satisfaction in the day's work and in the accomplishment of worthwhile life purposes is essential. There are apt to be two kinds of nurses who lack this — the retired nurse, and the nurse who, though not retired, has grown stale on the job and finds her work either distasteful or boring.

SOME SUGGESTED SOLUTIONS

Assessment of the Assets and Liabilities of the Older Nurse: In order to make wise adjustments, nurses must be aware of the results of psychological studies of the aging of human abilities. It would appear that physical and physiological functions are the first to start declining with age. Then psychological functions, like reaction-time, which mental alertness quickness of response, are apt to decline. These psychological functions are dependent on physiological ones like vision, hearing and muscular response, which are likely to weaken with age. Immediate memory is also apt to decline. It is a common observation that old people are apt to forget recent experiences. Impaired efficiency of immediate memory is, therefore, apt to be one of the weaknesses of later life. The ability to learn new things reaches its maximum in the early twenties and then starts declining slowly. However, this decline can be greatly overrated. Those individuals who continue with new learning during their mature years are apt to be able to continue without too much loss until senility, as such, sets in. It should be remembered that many older people do not learn new things either because of the cumulative effect of poor work habits or because they haven't sufficient

desire or incentive to learn. When it comes to old learning, much of this is quite well retained. The one bright spot in the abilities of older folk is that their judgment and reasoning ability is apt to continue at its peak much longer than their other mental abilities. Milesi says: "In the test results for performances, not necessitating quickness in reaction, but depending solely on comprehension, reasoning and judgment; in matters where experience may contribute to the quickness of response; older adults appear most nearly to maintain their characteristic mature scoring level while they continue to maintain mental practice and interest." In this particular field there is apparently a great waste, in our society, in utilizing the experience and judgment of older people. With regard to creative imagination, this is apparently ageless. Individuals may think creatively and make valuable contributions at practically every chronological age level beyond early youth. Some scientists have made their chief contribution after the age of eighty. It would seem that the contributions of older folk to the intelligent solution of problems depend on many other factors than mere age — an eagerness to learn and study, good work and study habits, and the opportunity to make their contribution. How help may be given to nurses so that they will make effective contributions in the latter half of their career will be discussed in the following sections.

The In-Service Education of Nurses: It is vital that the graduate nurse continue to study in a systematic fashion from the day that she leaves the training school. This is for several reasons. First of all, she must during her professional career, compete with her fel-

lows, some of whom, if trained ten or fifteen years later than she, may be more up-to-date. Being up-to-date has nothing to do with age as such. Either one is possessed of the most recent knowledge and is proficient in the newest techniques, or one is not. It doesn't matter much whether the nurse who is behind the times is twenty-five or fifty-five years of age, except that the latter is more apt to be suspected of being outof-date. It is vital that every graduate nurse see to it that, by systematic reading of professional journals and books and by periodic refresher courses, she keeps herself up-to-date. She does not need to fall behind. If she does she may expect to be pushed aside.

In-service professional education is vital from three other standpoints. First of all, it will help to ensure that the nurse continues to find in her profession a sense of achievement, of recognition and of personal worth. These come from efficiency in doing one's job and a keen interest in improving that efficiency. Secondly, as has been pointed out above, the nurse who keeps learning new things will be able to continue learning up to the onset of senility. Thirdly, the nurse who is able to suggest fresh ideas of her own is the one who has been stimulated by constant contact with fresh knowledge gleaned from her reading, as well as from reflection upon both her reading and her experience.

Professional associations of nurses should greatly extend the organization of refresher courses. Perhaps, too, they might consider the advisability of making continuance on the nurses' register contingent upon attendance at refresher courses at stated intervals, say, once in every five years.

Adult Education for Older Nurses: Entirely aside from in-service professional education, all nurses, like all other citizens, should participate in a well-organized adult education program. Such a program should serve two pur-

^{1.} Miles, W. R. R., Psychological Aspects of Aging in "Problems of Aging." Edited by E. V. Coundry, Baltimore, 1942. Williams and Wilkins.

poses. First of all, it should develop community study and discussion of all sorts of community, and national and international problems. The greatest problem of our time is how to live together co-operatively in both smaller and larger communities. Only co-operative study and effort can solve this problem. Secondly, an adult education program should promote the development of individual self-expression through handicrafts, music, art, dramatics, and the enjoyment of good literature. Both of these services of adult education must be available for the older nurse, both before and after retirement. Retired persons need study and discussion clubs, and handicraft, music and art centres quite as much as adolescents need teen-age centres. Adult education is growing rapidly towards fulfilling its legitimate function of helping adults to solve their daily problems and to meet their daily needs. It must do this for the older nurse whether retired or not. Life can be rich and meaningful so long as there is the sharing with others of the solving of personal, community, national and international problems.

Vocational Guidance for Older Nurses: Because vocational guidance is relatively new, those interested in it are apt to confine their activities to teenagers. In the near future vocational guidance will not stop with the choosing of a job in youth or early adulthood. It will be a service which will continue throughout the life-span. The war has accentuated this need. The requirements of modern warfare are such that many jobs can be done effectively only by those in the twenties, and others by those not older than the thirties. This is true of civilian jobs too. In the future, vocational guidance will be busy shifting and adjusting individuals within their occupations to the jobs they can do best as they grow older. In the past, a person was supposed to work at one job from youth until retiring age in

spite of the obvious fact that his physical abilities declined while his experience and knowledge increased. There ought to be a gradual shifting of personnel as they grow older to jobs which mature persons can do better than younger ones. If this were done, it would not be a case of retiring from but of retiring to. In the case of nurses, many older ones still in service are not suited for the jobs they do. Within the profession there is room for a wide range of skills and abilities. Some of these are possessed in highest degree by older nurses, others by younger nurses. The sensible thing to do would be not to require a nurse of sixty to do what she could have done well at thirty. Rather she should be shifted, without loss of prestige, to a job which, at sixty, she can do much better than at thirty because of her experience and her continued growth. It is, of course, her job to see that she has grown in knowledge and experience through the years so that, at sixty, she has resources which she didn't have at thirty. There are many contributions to society which those over sixty can make when we think in terms of vocational guidance as a life-long process and not merely a matter of picking a job for an eighteen-year-old with the assumption that it is equally suitable for her at twenty and at sixty.

Counselling Service for Older Nurses: In the United States there has been a rapid growth in old-age counselling centres where the older citizens are helped to solve their problems and to make wise adjustments. In the case of nurses, this service must be performed by someone connected with the provincial offices of the nurses' associations. At the least it should be made possible by such associations.

Heading Off Maladjustments: The time to head off the maladjustments of later life is in early life — the earlier the better. It would seem that counselling services should be provided for

younger nurses so that they may look ahead and plan, not only for happiness and efficiency at the moment, but for a full life-time of such happiness and efficiency.

Human life is full of problems. Down through the ages man has set himself to the solution of these problems. One after another they have yielded to intelligence, persistently applied. The experience of the race should give hope that every problem of human living will, in the long run (and often in the short run), be solved by intelligent and cooperative effort, the problems of the older nurse being no exception.

Tick and Insect Borne Diseases

F. A. HUMPHREYS, D.V.Sc.

In Canada and the United States a number of diseases are transmitted by the Rocky Mountain wood tick (Dermacentor andersonii) and American dog tick (Dermacentor variabilis), both of which are widely distributed. The so-called wood tick is not found on trees, as many people think, but on grass, small brush, and weeds native to open spaces. Ticks always tend to crawl upward. Hence protective clothing, such as high boots, leggings or puttees, should be worn in tick-infested areas. The undiscovered tick is thus prevented from attaching until it reaches the neck or head where it is more likely to be seen or felt. In attaching, a tick may cause a slight sting, but usually it attaches without causing any noticeable irritation whatever because the hypostome seems to gently anesthetize the skin as it penetrates. Occasionally the site of attachment becomes an ulcer, which is extremely slow in healing. When a tick is found attached it is best to remove it immediately for each added moment increases the danger of spotted fever being transmitted, although ticks rarely transmit infection until they have fed from four to six hours. The easiest and quickest method of removing them is to gently pull the tick off with the fingers. When sterile instruments are at hand ticks of any species may be removed easily by pulling the tick gently so as to make a tent of the skin surrounding the site of attachment and then slipping the point of a hypodermic or scalpel under the mouth parts. The instrument is then raised, thus removing the mouth parts with a minimum of tissue. Iodine, a silver nitrate pencil, or some other antiseptic should be applied to the site. There is no proven substance which can be placed either on the clothing or on the body to prevent tick attachment.

Tick paralysis is as yet something of a mystery. It not infrequently occurs about the fifth or sixth day following the attachment of an undiscovered female tick, usually when the tick is in a state of at least semi-engorgement. It is not often seen in children and young animals, and nearly always disappears promptly when the offending tick is removed, provided extremis has not been reached.

Infected ticks are extremely dangerous visitors, but fortunately the percentage that are infected is small. In the United States it is from less than 1 per cent up to 4 or 5 per cent. In Canada so far it is much less than that. Areas of infection seem scattered. Part of the work of the national health laboratories is in the nature of surveys to determine where areas of infection occur.

Two of the most widely known tick and insect borne diseases are Rocky Mountain spotted fever and typhus fever. They are caused by Rickettsiae, so called in honour of Dr. Howard Taylor Ricketts, who was the first, in 1906, to prove that spotted fever is carried by ticks. Rickettsiae may be considered as midway between bacteria and viruses. They can readily be seen when properly stained and are not filterable, but like the viruses, cannot be grown on lifeless media. Although spotted fever has been diagnosed in Western Canada a number of times in recent years, the causative rickettsia was isolated for the first time in this country only last year when it was recovered from a fatal case of the disease in a man in Southern Alberta.

Rocky Mountain spotted fever is not confined to the mountainous regions as originally thought, but is now known to have a wide distribution extending into the Eastern United States. A few cases have been reported in British Columbia. and several have occurred in Alberta. The incubation period is from two to fourteen days. There may be a prodromal period of from two to fourteen days or longer, characterized by loss of appetite, irritability and malaise. The symptoms most often complained of at the onset are frontal and occipital headache, intense aching in the lumbar region and marked malaise. The typical rash is coloured from pale to bright rose and is commonly macular. It extends rapidly to all parts of the body including the palms of the hands, the soles of the feet and the mucous membrane of the mouth and throat. The febrile period is from two to three weeks, but may be longer or shorter. The maximum temperature may not be greater than 103°F. In recovery the temperature falls

by lysis and reaches normal by the end of the third week. In fatal attacks there is occasionally terminal hyperpyrexia, the temperature reaching as high as 108°F. The lungs are usually not involved, but a slight hacking, non-productive, bronchial cough is typical. Convalescence is slow, and complete recovery may require from one to several months, sometimes a year or even longer. This may be true of even relatively mild infections. Careful nursing is important. The patient should be kept at rest, avoiding overtreatment. Penicillin may be of value but the sulfa drugs are useless.

In diagnosis, Rocky Mountain spotted fever is sometimes confused with typhoid fever measles, scarlet fever, smallpox, post-measles, encephalitis, secondary syphilis, Colorado tick fever, and endemic typhus fever.

Typhus fever was long confused with typhoid and only in the last hundred years has it been possible to differentiate between them. The cause of typhoid was discovered in 1880, while the cause of typhus was not found until 1916. There are two types of typhus: (1) Murine or endemic which is rat-borne and transmitted by fleas; (2) European or epidemic which for centuries was common in the Old World and is louse-borne. It was known as gaol fever or ship fever. The word "typhus" means stupor, and this term was probably applied because of the extreme prostration which accompanies the infection.

In 1659 typhus fever was epidemic in Canada for the first time. It was brought to Quebec from France and spread rapidly among the inhabitants causing many deaths. It has always been a serious problem in armies. It played havoc with Napoleon's troops in their retreat from Moscow in 1812. In this famous rout, cold, famine and several other diseases played their parts, but typhus seems to have been the greatest factor in the defeat. It was also a ter-

rible scourge in the French and British armies, especially among the French armies in the Crimean War, 1854-1856, in which Florence Nightingale played such an important role.

Plague is one of the world's oldest diseases. The outbreaks of epidemic disease mentioned in the Bible were probably this infection, but the greatest outbreaks of it were those that occurred in the fifteenth, sixteenth and seventeenth centuries when it became known as the Black Death. In Europe about twenty-five million people perished from it, and in Great Britain alone one half to two thirds of the population are said to have died of it. It is usually spoken of as bubonic plague because of its tendency to form buboes, a bubo being a swollen and extremely painful lymphatic gland. The really dangerous form, though, is the pneumonic type which is seen when the infection colonizes in the lungs, as it often does. A bronchopneumonia then develops and the infected person, through coughing, is liable to infect every one who comes near.

Plague infection is, of course, carried by rats, although other rodents such as mice, ground squirrels, and ground hogs are susceptible. It is transmitted by fleas, and is continually being looked for in rats which may be introduced along the Pacific Coast from ships. Two years ago and again this year it was found in rats and mice in Tacoma. Some spectacular outbreaks have occurred in California. It first appeared there in 1900. Up to 1925, 405 cases occurred with 257 deaths. Of these, 46 were the pneumonic type, all but 3 of which died. Since then several more cases have occurred. The infection is picked up nearly every year in ground

squirrels somewhere in the Western States.

As an example of the infectivity of plague in Los Angeles in 1924, a Mexican woman died after four days of illness - no diagnosis. Three days later the woman's husband and a practical nurse who had nursed her were taken ill. Both died. An autopsy was carried out on the husband and the cause of death given as double pneumonia. A week later eighteen contacts had been admitted to hospital. All developed pneumonia and all died after an average illness of four days. All were friends and relatives of the original pa-

Tularemia is a plague-like disease of rabbits, ground squirrels, and other rodents. It is transmitted by ticks and biting flies. It is extremely infectious and causes a variety of symptoms in man, such as an ulcer at point of infection, swollen, painful glands, and pneumonia. The mortality is not high, possibly 5 to 10 per cent, but the illness may be lingering, varying from a few weeks to two years. The infection is widely distributed. It has been found in the Kootenays of British Columbia and at several points in Alberta and Saskatchewan.

Relapsing fever is caused by a spirochete and is transmitted by certain ticks and by lice. The greatest epidemics of it occur in North Africa and India, though numerous cases have occurred in the United States, and several have been reported in British Columbia. Six cases occurred at Trail in 1933. As the name indicates, it causes bouts of fever which tend to subside after a few days. but later return. Usually four or five relapses occur.

Preview

much used hospital equipment? W. J. ment and materials which should help us Coleman has given us some very useful to keep things going until the day when pointers on the care, maintenance and new supplies are once more available.

Are you having problems with the conservation of a wide variety of equip-

Interpretation of Medical Social Work

H. ALINE PAICE

In order to show something of the development of this branch of hospital care it is necessary to understand how it originated and what special emphasis may be noted in its growth. As all nurses know, the spirit of service to the sick is not new.

Throughout the history of the Christian church, the spiritual welfare of the sick has always claimed the attention of the clergy. In England, as early as 1791, the London Hospital organized a group of volunteers to follow patients into their own homes for the purpose of providing suitable aftercare. There are some fundamental differences, however, between the early concept of social service and that of the present day. Formerly, neither the clergy nor the friendly visitor co-operated closely and constantly with the doctor, nurse or community resources outside the hospital. It has remained for the hospital social worker of the present day to define and develop the function of the unofficial visitor.

The first effort to establish this form of hospital service was made by Sir Charles Locke in 1885. After many years of careful study of hospital systems he found there existed an appalling waste of skilled attention, time and material lavished on the patient, due to the absence of a connecting link between the hospital and the world outside. He made a report to a Select Committee of the House of Lords on his findings, which resulted in the appointment of the first Lady Almoner (Miss Mary Stewart) in the Royal Free Hospital, London, in 1895. Miss Stewart was a trained worker who had had considerable experience with the Charity Organization Society in London. She was the forerunner of the vast scheme of hospital social service which, in various guises, has gradually developed all over the world.

The development in North America is due in one case to a doctor and in the other to a nurse. It was Sir William Osler who between 1898-1900 started the idea. Dr. Osler taught the medical students the social as well as the medical aspects of tuberculosis. He made it possible for two third-year medical students to follow "the consumptive out-patients to their homes to investigate the conditions under which they lived and to see that the proper hygienic directions given in the hospital were actually carried out".1 Somewhat later, Miss Mary Wadley, superintendent of nurses, Bellevue Hospital, N.Y., required the nurses to visit in the homes of the patients to secure information pertinent to a fuller understanding of the conditions under which they lived. In this way, she helped them better to appreciate the connection between patients' illnesses and the problems of their daily lives. It was in recognition of this need that Dr. Richard C. Cabot, in 1905, started medical social work by securing permission from the Massachussetts General Hospital to actually bring a social worker into the hospital, to work under his direction with special patients whom he was treating in the ward and clinic. From this small beginning, the practice spread rapidly until today well over five hundred hospitals in the United States and Canada employ some 2,063 medical social workers. (1943 statistics). "As the movement grew, it was natural that various emphases developed. Administrators saw in this new personnel a resource for many other uses, such as collecting bills, preventing abuse of free facilities and doing many odd jobs for which no one else seemed

available".2 Because of this chaotic situation, and because those workers whose experience had continued more closely in line with the original concept were concerned with assuring a thoughtful and sound development for this emerging profession, in 1918, with Dr. Cabot's encouragement, they organized into a professional group known as the American Association of Hospital Social Workers. Within a few years, district sections were formed and one of the early ones was the Eastern Canada District, which started in 1923 with headquarters in Montreal.

As early as 1920, studies were undertaken to establish what might be considered the appropriate function of the hospital social worker. A committee of the American Hospital Association, which included members of the hospital social work organization, made the first of these studies and, in succeeding years, three others have been made by the professional association of medical social workers. The following points are today accepted as defining the function of the medical social workers:

(a) Practice of medical social case work: Inquiry into the social situation of hospital patients and the reporting of the findings to the responsible physician; determining, in collaboration with the physician, the factors in the social situation pertinent to the patient's health and stating these as medical social problems or diagnoses; setting up, in collaboration with the physician, a possible goal for the patient to aim for; distinguishing the role the social worker is to play in the plan for helping patient achieve the goal; executing the social worker's part in the plan.3

In addition to this, the Statement of Standards, accepted by the American Association of Medical Social Workers in May, 1936, and revised in May, 1940 lists the following additional functions:

(b) Development of the medical social program within the medical institution.

- (c) Participation in the development of social and health programs in the community.
- (d) Participation in the educational program for professional personnel.
 - (e) Medical social research.

Medical social casework begins its function when the clinician desires the worker's assistance and when she is released from pressure of miscellaneous tasks that divert her from giving a high quality of social casework service. Social Service Departments are often asked to participate in the teaching of student nurses when the school of nursing wishes to incorporate some aspects of medical social work in their curriculum and if there is adequate social service staff, a worker is delegated to the teaching department to work out a suitable plan for student nurses. In this article we shall discuss only the main top'c of the medical social worker's function as a member of the "medical team" made up of the doctor, nurse and social worker, each bringing his or her unique contribution to the care of the patient in the ward or the clinic of the hospital.

FUNCTION

The function of medical social work is to help sick people with problems arising from their illness or medical care. Its most characteristic feature is the individualization of the patient, his particular needs, and his reactions to his illness, treatment, and his personal relationships. All of these factors must be properly understood by the social worker to enable her to gain sufficient insight to meet the patient's needs. Her best sources of information are the physician and nurse. Mutual understanding of each other's function and goal is vital to success.

As the physician sees his patient in the ward or clinic, he is able to see him in only a comparatively isolated way. The patient, for the time being, is separated physically from his natural setting. He may be confused by the number of people who serve him, the highly technical procedures, the presence of other sick people, the separation from his home and family, the difficulties of carrying out the doctor's recommendations, lack of understanding of his condition, fear of the future. The patient with a severe heart condition, faced with the necessity of a complete change of work, or even cessation of it, when he has a family dependent upon him, has a serious adjustment to make. His response to these problems, and his ability to get and use help in meeting them at an early point, often affects the way he responds to medical care. The patient with gastric ulcer must often have help over a long period to adapt himself to a diet sometimes difficult to get, or at variance with his habits of eating, to say nothing of the necessity of living calmly in the face of worries or strains. The surgical patient who has suffered the loss of an arm or leg needs understanding case treatment, if he is to go forward in life as an adequate person. One could enumerate many such illustrations but, through them all, runs the need for the skilled case work relationship which can help build strength for self-direction and readjustment, and bring forward those resources within the patient, in his family, in society, which the patient can use effectively while medical treatment proceeds and as he gradually becomes adjusted to his limitations.

Sometimes the medical social worker needs only a short contact with the patient to bring about a release from tension, fear and insecurity. While the patient, suddenly faced with a diagnosis such as tuberculosis, syphilis, or a serious operation, may need only one, two or three interviews with the medical social case worker in order to see his way clearly, to rally his resources, and to go forward, he may also need much longer and more comprehensive treatment. In addition to her understanding of the

social implications of the patient's disease, and her case work skill in interviewing, there is an added value in her immediate availability so that the doctor or nurse can bring her in at the crucial point.

There is an increasing tendency to use the skills of the medical social worker at the admitting desk and in the social review of all cases coming to certain clinics or wards. The value of having the patient meet the trained medical social case worker at his first contact with the clinic or hospital is that, not only his medical and social needs are considered together and integrated in the decision to admit him to free, partpay, or full-pay services, but also that any medical social treatment which he may need in his later care is started at that point. The probable expense of his own medical care, the relation of his particular illness to his later ability to earn, to the other expenses of his family, and to his standard of living, are all balanced in the light of the policies of the hospital and its particular facilities for medical care. The case work approach, so important if there is to be lack of tension, readiness to follow advice, and the best possible outcome of his medical treatment, if begun at the admitting desk may often preclude later long and expensive readjustments, or even ultimate failure to help him adequately. This type of service is of value only when there is an adequate staff available for the full treatment of which these services may be simply the first step - an important one - but effective only if it can be carried through in indicated instances. As Dr. Cabot said, "Quick judgment necessary in these services calls for the best trained case workers available at these points, and one would warn against the establishment of social admitting, or 100 per cent social review, until adequately trained and experienced personnel is available for both types of service."

Before interviewing the patient, the worker must have a complete picture, both from the medical record and from the doctor-in-charge, and a knowledge of any previous experience which the patient may have had with other social agencies in the community, in order to be as much use as possible to him. It is by the process of interviewing that a helpful relationship is built up between worker and patient so that he can express his problems and try to solve them.

The following case illustrations will give an idea of our work with the patients:

Case 1. The patient, a single Ukrainian girl, age 30, with rheumatic heart disease with mitral stenosis and aortic insufficiency and with chronic passive congestion of the lungs, was referred to the medical social worker for convalescent care by the resident doctor. The patient had scarlet fever at the age of 17 and was hospitalized for rheumatic fever twice in the next two years. She is a pretty, intelligent, very sensitive girl. She is demanding and sulky when she feels people do not like her. Her mother died when she was born and she was placed with foster parents. They made her feel unwanted and unloved. At the age of 12 her foster mother died and she tried living with her real father. She was very unhappy there since he had remarried and had several children. The patient went to work as a maid at 13 years of age and has supported herself ever since. She has not seen her father since she left home.

The patient needs a lot of understanding and attention, more than it is possible for most people or institutions to give her. We have tried to give her this with the aim of helping her obtain medical care and to accept the limitations illness creates for living a full and normal life. For a year our activity has consisted of helping in every area arising from her medical social needs. She was referred to a family welfare agency for financial relief. The patient has made very uneven progress and is at present in a hospital for chronic and incurable diseases because no other placement is available at this time. She has found it very difficult to adjust to this hospital since the majority of patients are aged and there is a high death

rate. We have continued to visit and write her since there is no social service department in her present hospital. The patient depends on us to help her and knows that our interest will continue until she is ready to carry on alone.

Case 2. A fall outside the house where she worked as a personal maid created a problem for Miss M, a 58-year-old single woman who had come to Canada about fifteen years ago direct from Paris. On admission to hospital she was found to have a fracture of the lower right tibia. A bone plating was done and cast applied above the knee. Miss M. was referred to the medical social worker by the head nurse on the day of admission because she was upset about the accident and would have to make plans for convalescence and ultimately a readjustment to a different type of work. She has an attractive manner and a sensitive face; she looks younger than her years. She speaks English quickly and fluently but with a marked French accent. During the first interview she cried often, repeatedly stating that she did not seem able to control herself and could not think clearly about what she should do. She had a real fear that she would never be able to walk again; her physical disability made her feel insecure because she had to depend upon abilities other than her own for direction. She explained that she was the only child of deaf parents, therefore she had early learned to think for herself and find answers to her own questions. Because she was born late in her mother's life, she thought she had not the same physical stamina to counteract the effects of such an accident. Although she was trained as a seamstress in Paris, in order to save money for her future in Canada she had also worked as a personal maid. She foresaw the savings, with which she had hoped to purchase a boarding house, being used up in payment for treatment and a long convalescence. Fortunately she had a room in the city which she had kept for her use even while she worked at private residences. This she can turn to when she is able to walk on crutches.

Medical social case treatment, during the first four interviews, was directed towards providing a release from these fears, helping her to regain more of her former emotional stability. The worker discussed the fact that she, like many people, was hypersensitive and easily overcome by anything

related to herself. She was given reassurance that because she was able to plan for herself before the accident, she would in time be able to do so again. In addition, she needed a careful explanation by the doctor about her fracture and the exact treatment she would require before she could use her leg again. She was then ready to use the convalescent hospital available where, over an eight-week period, she was helped to walk and learned to look after herself. This lessened her feeling of helplessness and made her more prepared to look after herself in her own room.

While this patient has not yet the use of her leg, from the time of her admission to the convalescent hospital she has made her own plans, using the medical social worker as a sounding board. Her confidence in the medical treatment, continued careful interpretation from the doctor, and her increasing adjustment to her disability, indicate that medical social case treatment can be discontinued shortly.

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From One Post-war Period to Another in Canada and India

EDITH BUCHANAN

back with my father on his rounds, to of the jungles of the Vindya mountains

As a child, I had ridden out on horse- those little homes in scattered clearings



Dr. Buchanan visited the people in their homes.

in Central India. I had watched him pull out arrows deeply imbedded in flesh and bone. I had watched him stitch up ugly gashes, seen him with pneumonia patients, seen him vaccinating the whole community, seen him dosing all the school children and trying to get down the size of those chronically enlarged spleens. I had gone with mother (who also was a doctor) in the evening when she visited sick babies and mothers; seen her work to supplement those fever and dysentery diets; and heard her teaching relatives how to carry on till the next visit. I remember her working all night over people with snake bite, working over children with convulsions, going out at all hours to people who were sick, poring over her medical books looking up the treatments - and I remember her scrubbing me with soap and water and admonitions until I was almost raw, after I had picked up a medicine bottle returned from a cholera house, Yes, I thought I remembered India, when I went back at the beginning of 1936 but what a lot I had forgotten! Even the last word of the language!

I needed a job so I went up at the beginning of the hot weather, after a short visit in the countryside of my childhood, to a mission hospital in the Punjab that needed a nurse. It was dirty and hot on the train. Fifteen minutes after a hopeful wiping of the seats, a pall of dust and sand settled down that you could write your name in, your throat dried up, and earth gritted between your teeth.

When I arrived I was shown into a bare bedroom and discovered that I needed to supply sheets, towels, curtains, pillow and mattress, everything of my own except the actual sticks of wooden furniture and the big oval zinc wash tubs, cleanliness-is-next-to-Godliness arrangement, with a kerosene oil tin of hot water beside it. So I sent away for linen by mail, hauled out all the paraphenalia of apron and uniform for the morning, and slept very comfortably on



Primitive hunting weapons.

the tape bed with a sheet over it (it's the cool way to sleep in hot weather).

The next day we started with a breakfast that included chapatties (unleavened bread) and went right over, with that as a sort of leaden anchor amidriff, to the hospital. There were sometimes three or four people who spoke English and sometimes none in that hospital. Well, if you have to learn a language it soon comes to you, and that summer between dust storms and flies, prickly heat, dysentery and sore eyes, I learned quite a lot, and saw a lot of life-people rich and poor, in gorgeous raiment or in rags — but always colourful, a never-ending pageant of people. There were long moonlight nights, too, when we slept out of doors; and others, longer, and less lovely, when we fled indoors before a rising dust storm and tossed in dust-choked heat as the lightning flashed and the eucalyptus trees swirled and lashed in the earthy air, like furious breakers in a gale. A long siege as a patient was the climax of the summer, ending up in a big Calcutta hospital. It overlooked a main

thoroughfare of the city, where herds of cattle wandered all through the night and into the early hours of the morning, and sheeted figures, like the dead, slept out on cots in the street for air. Fans whirred all night over our beds, and still our foreheads were damp with perspiration.

And that may be the colour of the whole Indian experience for a lot of people who go to India in the army or on business, and perhaps never get a chance to like India because of their own physiological difficulties in the first vear or two before immunity is built up and adjustment made. So don't be surprised if some of our army men and women don't like it. Many of them have had a bad time physically with malaria and dysentery. Some of them, however, may get a chance as I did to see that same Northern Punjab in the cold weather, which feels colder than England and everybody knows how much colder England feels than Canada! (I certainly never wore winter woollies in Canada!) Anyway, the Punjab is a land of roses in the winter and of all the flowers you care to grow. The vast wheat fields stretch to the horizon, watered by a network of canals from the five rivers that name the province. Far across the green plain, against a clear blue sky at sunset, may be seen the rosy snow-covered mountains — the mother-of-pearl fairyland of Kashmere. And by the roadside long caravans of oxcarts camp for the night, smoke winds up from fires of cow-dung cake, oxen chew their cud while bells tinkle drowsily and camels settle down lugubriously and disgustedly for the night.

I had taken my instructor's certificate at McGill under the inspiration of Miss Lindeburgh, and had taught at the Royal Victoria Hospital for three years before I went out, so I was looking for a job in nursing education rather than supervision and administration. In November, 1937, I went to the Lady Hardinge Medical College Hospital in

Delhi to get some experience in different fields and with a view to going into my own particular branch of work.

Delhi is the Ottawa or Washington of India, except that it stretches far back through a long line of royal capitals to an ancient and almost prehistoric past. It is built at the crossing point of the old caravan routes going from East to West and from North to South. It has in it the "star of India" of the future, blended with all the colour of the past all the romance of "The Golden Road Samarkand" and the Caliphs of Bagdad". Fine modern buildings and some of the noblest architecture of the great Moghul period are to be found in and near Delhi. The famous Taj Mahal is less than one hundred miles away; Fathepur Sikri, also the rose-coloured sleeping city of the great Emperor Akbar (contemporary of Queen Elizabeth), and his glistening tomb at Sikandra, open in high marblescreened solitude to sun and sky.

You may be very miserable in Delhi if your life is still all prickly heat and dysentery, for it has six very hot dusty summer months. If, however, you have accomplished some physiological adjustment, got some immunity, a healthy routine, and a zest for life again, then it is a place to delight mind and fancy alike. For me it was fortunate in progressive professional interest as well.

At the Lady Hardinge, Dr. Ruth Young was medical superintendent of the Hospital and principal of the Medical College. She had done much in health and preventive work for India, and had travelled widely under the Rockefeller Foundation, visiting Canada, the United States and many other countries. (She has since been called out to advise on health matters in Abyssinia.) Miss Winter, D.N. (London University), was the superintendent of nurses. She also had had wide experience in India, and in addition had been for five years on the staff of the College of Nursing in London. The Lady Hardinge



Screet scene in Delhi.

Medical College, School of Nursing and School of Pharmacy all are organized to give professional training to Indian women, and the hospital similarly is designed to serve Indian women and children. I couldn't have found a more interesting institution in which to work and learn. Miss Winter "pushed" me about from experience to experiencemuch as Miss Hersey had done in my own hospital-to get the wider background and knowledge which helps so much in teaching. I started as "hospital steward" with the function of ordering, keeping track of, and distributing all linen supplies and managing the sewing department (five cross-legged Mohammedan tailors on a verandah). I also had direct charge of the kitchens. The hospital was being reorganized to include better and more varied Indian diets. I had the fun of burning the midnight oil night after night working out and balancing Indian diets for vegetarian and non-vegetarian patients; working out costs; presenting the new diets to the hospital committee for approval. Non-vegetarian kitchens were introduced in addition to the vegetarian.

Five high caste Hindu women cooked on the vegetarian side, sitting on the floor over fires of coals, making some six hundred chapatties a day in addition to the other dishes. I might neither touch anything on that side, nor so much as step inside the door, for fear of polluting the food. Two Mohammedan women cooked on the other side. Only one woman out of the seven could read and write a little, so that each kitchen had its own hot food carriers for every ward marked in colour to distinguish them. Each kitchen had a slate ruled in sections with rows of solid circles to show the numbers in each ward on the various diets. Incidentally, I found these same almost illiterate women interested, open-minded and eager to do their part towards improving hospital diets, even when it entailed more work and worry. So the next time you find your reforms blocked, and people unwilling to accept change, you had better come and borrow keen bright-eyed Sobadra, the high caste head cook woman-to help you. The post of "diet sister" was given me to pave the way for a trained nurse dietitian from the London Hospital, who

came out shortly after, to take over and build up the whole department.

Since I could not qualify as a permanent "senior sister" without taking midwifery I then went down to Madras as a student nurse again to take a course. I have always been exceedingly interested to know what it is like to be a student nurse in India, and to see what a big hospital is like from below and inside as it were.

Madras is rather more different from the Punjab than Egypt from France or Italy. Culture, religion, appearance of its people, speech, language derivations - all are different. Again, I had to pick up as much as I could of the language for it was routine to be left alone with a ward full of patients on evening duties. Sometimes there would be a Mohammedan woman speaking a corrupt form of the Urdu or Hindustani of the North, and I could use her to help me to explain things. Sometimes there would be no one who spoke either Hindustani or English and then came the discovery of what wonderful dramatic talent there is in all of us. It's amazing how much you can explain by smile and gesture if you have to.

Family illness called me away from Madras, but I later finished up my midwifery at Delhi and did a junior sister's work in a gynaecological ward while doing it, which gave me another useful close experience with patients, student nurses and doctors. As soon as my examinations were over I took over the teaching in the school of nursing, following a sister tutor from St. Thomas's Hospital, London, with her instructor's certificate from King's College, who had just married. I started right in with a preliminary training school group. Miss Winter helped me in adjusting to the classes of student nurses, drawn from all over India, of such different language, religious and cultural groups. She helped me to adjust to the very different system of nursing also, based on the English system. She herself taught, did a lot of testing, and helped in organizing the whole programme. She was always helping me in practical ways—for example—by noting suitable patients for clinical teaching as she made her rounds. Since I had most of the organized teaching for the two classes in each of the three years (with the exception of doctor's lectures) it was a sound way of making ward teaching practicable in a heavy programme. In the wards, sisters who were able followed the English tradition and did a lot of informal bedside teaching. Others did less.

Those years of work under Miss Winter were a great help and inspiration. Much was being done in an organized scientific way to improve the hospital, to improve nursing care and, basic to it all, to improve nursing education. Gradually a waiting list of student nurse applicants had grown, and the school was able to choose those who were matriculants, those who had one or two years of university work, and even a Bachelor's Degree. More than that, as in other improved schools, students of different cultural groups were seeking admission, and from all over India. They came, and will come, for two definite reasons - first, for the clear organized learning opportunity provided; secondly, for the properly supervised residential life with a real care for diet and health and some guidance in that first experience of freedom after the very strict seclusion of boarding school or Indian home. While some 80 per cent of India's nurses are Indian Christian Anglo-Indian women, including many daughters of teachers, ministers, doctors, etc., there are also students in smaller numbers (some 20 per cent) from all the other religious and cultural groups. 1 have had students who were Rajputs, Sikhs, Brahmins, etc. (occasional ones were widows). I have had Mo-

^{1.} Journal of the Christian Medical Association of India, Burma and Ceylon, Sept. 1944, p. 197.

hammedans and Parsees. (The Parsees are a small highly intellectual group, very influential in hospital work in Bombay; Miss Adranvalla, a Parsee nurse, is nursing superintendent of the great J. J. group of hospitals in that city). Most of the students from these varied religious and cultural groups come from families where a member is a doctor, or is in the army or other service, in law or in one of the professions. One was the daughter of a Rai Bahadur (equivalent of "Sir"), another of a Commissioner, another of a Post-Master General, another of a Master of one of the most select boys' schools in India, etc. They come from all over India and from outside India as well. Many know four or five languages, including English, and learn Urdu, the language of their Delhi patients, during their training. We used Urdu a good deal in informal discussion and explanation. Visual aids, the laboratory method demonstration and return demonstration. assignment, discussion and question student participation of every sort and close contact with the student are obviously even more important than in teaching a single-language group. There is just the same quick response and lighting of the eye that you see in any keen

intelligent group of young women, who are getting satisfaction in preparing themselves scientifically for a chosen profession, A joke and laughter lighten teaching situations in any group and perhaps even more if the weather is hot and the "loo" is blowing (the desert wind). They all lived in the same nurses' home, ate in the same dining-room - although some ate vegetarian and others nonvegetarian dishes. They all did the same things on the wards, including the giving of bedpans. Given any sort of a lead from the head nurse (or sister) in doing that sort of thing herself, they were only too quick to play their full parts in the complete care of the patient. Some indeed were all the more conscientious to do things that were difficult to them, just because they had made up their minds so thoroughly to undertake the whole of nursing.

(Editor's Note: This fascinating story of the joys and tribulations of nursing in India will be concluded in next month's issue. In it, Miss Buchanan's sterling analysis of the future possibilities for nursing points the way to a new era. If you are interested in work in an exotic foreign land, do not miss the final instalment.)

The Story of Joey

INEZ NESSET

Joey and Johnny, twins, two months, four days premature, were born December 14, 1944, at the Paddockwood Red Cross Outpost. Johnny, hydrocephalic, two pounds, nine ounces in weight, died four hours after birth. Blonde, twelve-inch Joey, minus eyebrows, lashes, toe and fingernails, two pounds, one-and-a-half ounces, lived. His head measured eight inches in cir-

cumference, neck four inches, footlength one inch. An ordinary wedding ring slid up over his elbow.

Joey lived; it is remarkable. Perhaps he survived only because a suitable feeding was found. Mother's milk was not available. Borden's Lactogen, cows' milk were tried in turn, and finally a Carnation milk formula agreed. Constant artificial heat was supplied by four



Joey at two and a half months.

hot water bottles; a 94° room temperature was required night and day; he was soaked in protein fat five times every twenty-four hours and wrapped in non-absorbent cotton. Blue or sinking spells left him limp once or twice a night. Some of these were severe enough that 3 minims of Coramine were needed to revive him. Until his sixth day Joey didn't even whine to warn his nurse of anything amiss.

Joey at twenty-seven days of age was limp, jaundiced and incredibly old in appearance. He weighed a scant one pound, nine ounces. He refused to swal-



Four months. Note size of doll.

low, so was fed by means of a tiny catheter one teaspoonful of formula every hour, day and night, for fortynine hours. From then on he improved and gradually increased in weight. His colour turned to pink. Once a day he was given two drops of Ostogen, and seven drops of Ferrochloral in water. By the end of the second month Joey was able to take two ounces of formula; the high-pitched squeak was replaced with a normal cry; Joey could perspire and his artificial heat was reduced to one hot water bottle at his feet; eye lashes began to grow; fingernails appeared and he began to wake every two hours for his feedings.

At three months of age Joey ate every three hours, took two and a half ounces of a two-in-six Carnation formula. He eliminated twice a day without an enema, if given five drops of castor oil every ten days. Syrup in the formula merely gave him distress if increased. Hard and fast rules as to feeding or care did not apply with him. His nurse found him a tentative little human. She knew he must be five pounds at least before being discharged from the Outpost Hospital.

Joey, at four and a half months, weighed five pounds, five ounces. He towered fifteen inches in height on tiptoes. Three ounces of formula were taken from an ordinary feeding bottle in less than half an hour, every three hours. Joey smiled fleetingly and developed a temper. He disliked other babies, showing much jealousy if his nurse held one. His measurements were as follows: hat, thirteen inches; collar, twelve inches; boot, two and a half inches.

Joey is the eighth child in his family. He has three sisters and one brother living. To date he seems to be gaining slowly but steadily in weight from reports sent in by his mother, as Joey went home when four and a half months old.

Worried about your Christmas shopping? Let us help you by mailing in your gift subscriptions to the *Journal* early.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses
Association

Institute on Family Health Counselling

ISOBEL BLACK

For the week of June 18, the public health nurses of Winnipeg enjoyed the stimulating comradeship of group study on topics which are basic to public health nursing. Our thinking was guided by Miss Frances Benjamin, Parent Education Consultant of the Nursing Bureau of the Michigan State Health Department. Miss Benjamin was brought to Winnipeg by the School of Nursing Education of the University of Manitoba.

In planning our Institute we felt that what we needed most as public health nurses was to improve our methods of family health counselling. We realized that in addition to a knowledge of interviewing techniques, this would require a deepening of our understanding of family living and of the feelings of people as they meet the most meaningful of their experiences within the family. Do we really understand what it means to all members of the family to prepare for the new baby, to adjust to the illness of one member, especially such illnesses as tuberculosis and syphilis? Do we really understand the relationship of parents and children? We were aware of our need to become more understanding people in order to be effective public health nurses. We described our needs to Miss Benjamin and she planned the following topics for discussion:

The Family Today — The Contribution of the Nurse

Maternity — a Shared Family Experience The Maternity Group

The Parents' Care and Guidance of Children in the Home

The Infant

The Older Child

The Family and Community Agencies -

Services to Supplement the Home

The Child Health Conference

The Church, Library, School

The Family Meets the Problem of Com-

municable Disease

The Essentials of the Interview with Individuals and Parents

Materials:

Useful to Parents in Understanding

Their Children and Themselves

The Professional Development of the Nurse

The Veteran Returns to His Family and Community.

It is always reassuring to be reminded of one's importance in a vital cause. During our first meeting we experienced this satisfaction. Among the many highly trained workers helping the family to make the wholesome adjustment necessary for the development of children into healthy, happy and useful members of society the public health nurse has a unique and basic contribution to make. For instance, what other family counsellor is associated with the

family before a crisis arises? The public health nurse works closely with families over a long period of time covering normal experiences as well as crises. She is with the family when it meets the most vital experiences concerned with its existence as a family and with the care and guidance of children. During the maternity cycle the public health nurse is close to the family providing guidance in the preparation for and adjustment to the new member. This gives her an opportunity to help all members to find this a maturing experience and to play their parts in giving the baby the best start towards wholesome living.

Once we were sure of our place in helping parents to create the kind of family life which promotes health and the happy adjustment that is such a vital part of health, we were ready to turn our thoughts to the study of how to accomplish our objectives. As we thought together, we realized that we now have knowledge in advance of our ability to apply it. We must increase our skills in working successfully with people. To do this we found the nurse must be a calm, accepting person who can accept a family at its own level, appreciating its assets and willing to allow the members to meet their needs in their own way, using the nurse as a resource person who can help by sharing her knowledge without imposing her solution. She interprets health and the meaning of children's behaviour in this light of normal development. She strengthens the resources already within the family. The nurse must train herself to see the resources the family brings to the situation. What are the strengths of the family? What are the positive factors in the situation? It is so much easier to see problems to solve, the weaknesses of the family and all the negative factors in the situation, that sometimes the assets are obscured. Nevertheless the nurse must be aware of them. It is those strengths that the family will use with our help to solve its problems and build a more healthful way of living. We studied an actual record and found many positive factors in a "problem" family. Although there were many negative factors such as poverty, low level of intelligence, poor house-keeping, crowded living conditions and poor adjustment of a school child, we found a number of values. There was evidence of mutual trust and affection, of the mother's interest in the children, of good meal planning and of an easy, happy home atmosphere. The father was able to work steadily. The school teacher and principal were interested and understanding. There was a good relationship between the nurse and the family, We had to look searchingly to find some of these assets but they were there.

We found also that the nurse must be an observing person if she is to understand the true nature of the situation facing the family, how the various members feel about it and what the positive factors are. She listens, she draws out, she notices and perhaps most important of all she records her observations. Later as she studies her record in the objective atmosphere of the office she is able to interpret her observations free from the responsibilities and tensions which may have been present in the home. Her observations become more meaningful and her insight is deepened.

An appreciative regard for children is important for the nurse in her family health work. As she discusses them, showing genuine interest, the mother is drawn out to talk about them also and the nurse learns much about the parents' relationship to the children and about the family life in general. She interprets the normality of growth, development and learning; the relationship of the physical to the psychological, and of past experience to present behaviour and future development. If the parents have this insight they will know how to give understanding guidance.

With Miss Benjamin's help we came to see that the public health nurse can make an important contribution to increasing parent's confidence and giving

parenthood status. It might help parents to realize that they are the most important people in the child's life and that they have a function which can be performed by no one else. Many mothers and fathers have a feeling of failure in their role as parents. An understanding nurse may be able to help them to see the tremendous contribution they have made unconsciously to their children and in this way give them much-needed encouragement. A family record was cited in which this was strikingly illustrated. A new baby was expected and one of the older children, a twelve-year-old boy, had asked questions about the changes in his mother's figure. The parents realized by the questions that the boy had some knowledge about reproduction and was indirectly asking for more information. They felt it was their duty to give him more knowledge of sex but because of their own training they were emotionally unable to tell him the facts. Consequently they felt they had failed. The nurse helped them greatly by enabling them to see that they had already played the basic role of parents in sex education by giving their children confidence in family life, in the relationship of parents with each other and with their children. They had given their son basic attitudes towards life in general which would carry over into his attitudes toward sex. Even if they had to leave the task of fact-telling to someone else they had already successfully accomplished the very important part that only parents can play.

When we were ready to study the interview, we found that our past discussions had given us sufficient under-

standing of how to establish good working relationships that we could formulate some principles of successful interviewing with little trouble. The same applied to our discussion on the returning soldier and his family. We could understand something of the experience of both the soldier abroad and the family at home during the war and how the experiences of each will relate to the problems of adjustment for both the soldier and his family. The public health nurse, by being an understanding and reassuring person, should be able to help families as they make these adjustments.

While studying the community and how it supplements the home, we saw the work of the public health nurse in strengthening and developing community facilities as she co-operates with representatives of other agencies, and as she helps families to be aware of their community needs and their responsibility in promoting facilities to meet them.

During our work and study we came to see that, "So men can reveal to you aught but that which already lies half asleep in the dawning of your knowledge."*

We are beginning to see that we cannot impose our knowledge. We can only help to reveal to people the rich resources hidden within themselves. The Institute was an experience of this type of learning. Miss Benjamin gave us a masterly demonstration of how this slumbering knowledge may be awakened by skilled leadership.

Combat Exhaustion

Combat exhaustion cases, known as shell shock in the last war and sometimes referred to as combat fatigue or operational fatigue, were treated more successfully in this war because of the high quality of personnel in the field, better methods and techniques, and of the greate t importance is the fact that psychiatrists got to the men sooner than ever

^{*}Kahlil Gibran - The Prophet.

before. Army psychiatrists did some of their most effective work right up near the front at the clearing stations.

There was some variation in the treatment given. Sedation, narco-synthesis, hypnosis, and the new technique of group psychotherapy were some of the methods of handling these battle-weary soldiers. The results of group psychotherapy were, in general, particularly encouraging.

Symptoms of combat exhaustion were increasing irritability, lack of interest in letters from friends or family, lack of interest in comrades, and the throwing away of equipment and food.

There was a direct ratio between the number of exhaustion cases and the intensity of combat. The number of combat exhaustion cases was almost always just about one-fifth the number of wounded cases.

Every man has his breaking point, according to psychiatrists. It is just a matter of how much stress and strain is put upon a man and for how long a period. The fact that combat exhaustion cases bore a direct

ratio to the number of wounded shows that as the battle became more intense the pressure was just that much heavier, causing more men to reach the breaking point.

A factor that lead to combat exhaustion was the martyr situation. When men were unavoidably marooned from the main body of troops so that the situation seemed hopeless, or when they were on a mission which they did not understand and which seemed futile or when they were isolated and lost their leader, the average man was more likely to become subject to combat exhaustion under such circumstances.

Combat exhaustion did not mean that a man was "yellow", or a coward. A big percentage of the combat exhaustion cases represent men who had had long months of service at the front as effective and brave fighting men. They simply came to the point where the human system could take no more. It is then that the psychiatrists start to care for the ailing soldier.

-News Notes No. 28.

Civilian Internees of Jap Prisons

American civilian internees of Japanese prison camps in the Philippines, who have recently been returned to the United States, were found in a survey by nutritional scientists of the Army Medical Department to be on the borderline state of extreme starvation.

According to the report, the food served the prisoners, in addition to being poorly cooked, consisted mainly of wilted greens, moldy corn, dirty rice, and a variety of sweet potato which was often rotten. This soon led to vitamin-deficiency diseases. Relief packages were allowed in the camp only twice during the period of internment, all market vendors were barred from the camp, and the only source of extra rations was the black market.

The report, in listing the effects of mal-

nutrition on the eight children born in the prison camps, noted that only three showed any signs of vitamin deficiency. This was attributed to the mild climate and sunshine of the Philippines. The average weight loss, during the time of internment, jumped from 13.5 pounds in 1942 to 20 pounds in the last six months before liberation.

The most common symptoms still evident in the liberated Americans is digestive upsets, easy fatiguability, and neuritis. Seventy-eight per cent of the internees, however, reported that they felt "fine" a few days after liberation. The rapidity of recovery of the adults and the relatively good condition of the children is a striking example of how quickly the human body will return to normal after semi-starvation.

-News Notes No. 28.

Remember your friends at Christmas with a subscription to the Journal.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

Renal Calculi

CATHERINE O'HANLEY

Gladys is twenty-nine years old, pale but well nourished. For the past few years she has suffered periodic attacks of pyelitis with frequency and vomiting. Treated in hospital in 1940, she has sinced enjoyed fair health. Three days previous to her admission hospital in February 4, 1942, Gladys suffered severe pain in lumbar region accompanied by frequency of urination and nausea. On admission by stretcher she seemed to be very ill and was suffering acutely. Rectal temperature was 105, pulse 98, respiration 22, blood pressure 140/90. Murphy drip was started at once and continued for seventy-two hours until she could no longer retain the fluid. Proctoclysis saline and glucose were given. Linseed poultices were applied every four hours to the lumbar area and codeine gr. 1/2 was given for pain. Blood picture showed hemoglobin 65, W.B.C. 26,000, R.B.C. 3,280,000, urinalysis, albumin +, pus +. A blood urea done the following morning showed 150 mg. per 100 cc. X-rays taken the same day revealed stones in both kidneys. After forty-eight hours her temperature became normal, and she seemed better but was unable to retain even water. For the next month, she was given an intravenous daily. Frequency had become considerably worse and large quantities of pus are passed daily.

On March 3 and 14 transfusion of

500 cc. citrated blood was given following which Gladys showed improvement, seemed to gain strength rapidly and was able to eat and retain her meals. On March 23 she was allowed up; four days later she had severe recurrence of pain in right kidney area occurring at intervals.

On April 28 a pyelotomy was performed and a large stone removed from the right kidney. She received regular post-operative care, and made satisfactory progress with the clips removed on the seventh day. Four days later severe pain occurred in the left kidney area with elevation of temperature to 102, pulse 100. Sulfathiazole was ordered grs. xxx to be given immediately then grs. xv every four hours for six doses, followed by grs. xv three times a day. This was discontinued three days later when patient could no longer tolerate the drug. The next day another blood transfusion was given. Nausea persisted for several days necessitating intravenouses of saline and glucose daily. The temperature now was normal, and the patient was allowed out of bed on the twenty-third days for fifteen minutes.

The blood picture of May 26 showed W.B.C. 8000, hemoglobin 75. Though her condition improved the patient was not well. X-ray revealed a stone in the left ureter and the urine was full of pus. On June 9 ureterotomy was per-

formed, and a stone 1 cm. by 6 cm. was removed from the left ureter just proximal to its entrance into the bladder. On the ninth post-operative day chills, accompanied by a sharp elevation of temperature and nausea, occurred. Neoprontosil grs. xxx was ordered and given at once, then grs. xv every four hours for six doses followed by grs. xv three times a day for three days. Thereafter the patient made good recovery and was allowed up on the fifteenth post-operative day. On the thirty-third day she was discharged feeling well but still troubled with considerable frequency, passing a large amount of pus, and having blood urea of 80.

On November 13, 1942, Gladys was again admitted, this time with frequency, difficulty and pain when voiding; she could scarcely tolerate the passing of a catheter, and the urine still contained large quantities of pus. She appeared quite healthy with blood pressure of 120/80. Blood chemistry on recheck was 80. She was given boracic bladder lavage for several days, and hexamine grs. 7-1/2 three times a day for three weeks. After this frequency still persisted, but pain on voiding was not so severe. One the twenty-second day there was an elevation of temperature to 102 with severe pain in lumbar region and vomiting. Neoprontosil was again ordered every four hours. During the three following days Gladys took chills daily, her temperature going as high as 104.8. At this time frequency was much worse and she suffered great irritation. Intravenous was given and argyrol 10 per cent instilled in the bladder. Ninety-six hours later the temperature was normal and, although frequency remained, the irritation was much relieved. Her condition remained much the same until January when a cystotomy was done. One month after the operation, the supra-pubic tube was removed, after which the patient voided without difficulty but suffered intense irritation at

times. Six days later she was out of bed but was not feeling well. Another x-ray taken revealed a stone in the left kidney, and she had the usual pyuria.

On March 10, the left renal calculus was removed. Kidney drainage was by means of a bottle attached to the bed. Each day the tube was irrigated with boracic solution and every second day argyrol 10 per cent was instilled into the kidney. The tube was removed on the eighth day. She was allowed out of bed on the fifteenth day. Dressings were changed frequently until the incision had healed. When discharged on March 29, blood urea was 66; frequency persisted but patient felt well. November 12, 1943, Gladys returned for a routine check-up. Examination showed a cystocele and excoriation and redness at mouth of urethral opening. Blood urea was 55 with only a small amount of pus in urine. Urea clearance was 12-27 per cent. Hexamine was ordered, to be continued until cancelled by the doctor. She was asked to return in six months time for check-up.

June 12, 1944, Gladys was admitted for re-check of blood chemistry and urine. This time she had extreme urgency and frequency, and was passing large quantities of pus daily. She now had prolapse of the bladder. She complained of severe pain in her chest also. X-ray taken of chest showed nothing abnormal. Urea was 60, W.B.C. 14,-000, hemoglobin 80, R.B.C. 4,200,-000. Bladder irrigations were given until return flow was clear. Hexamine was continued. On July 4 the patient was discharged feeling quite well, and asked to return later for treatment with penicillin. September 23, 1944 she was re-admitted for treatment with penicillin. She had no particular complaint except for the usual frequency. Urine culture grown for twenty-four hours showed almost pure staphylococci, but no tubercle bacilli. Urine contained pus 4+, albumin 2+, hemoglobin was 70,

W.B.C. 14,000, R.B.C. 3,373,000, urea 70. She complained of marked tenderness in both loins, and had a marked rectocele and cystocele. Penicillin 20,000 units was given every four hours until 1,300,000 units were received. After the administration of

penicillin the urine cleared up remarkably. Two negative cultures were obtained; frequency and burning disappeared but recurred to some extent on discontinuance of penicillin. Since discharge from hospital Gladys has been enjoying much better health.

Preparing Material for Radio

JEAN MASON

Radio today vies with the printed word as a means of publishing information. Anyone with a message for the public does only half a job if he does not use radio.

Local nurses' associations frequently have messages for the public which radio can help them give. Radio station managers are usually willing to co-operate by giving time if they feel that the message is of enough importance to enough people and if the program promises to entertain as well as instruct.

The simplest type of program is one in which one person speaks for a specified length of time. Unfortunately, this is usually the least effective type of program. Unless the speaker has an exceptionally good radio voice, it is difficult to hold the interest of a radio audience no matter how good the material may be, Both voice and material must be far better than would be necessary if the speaker were addressing an audience whom he could see and by whom he could be seen. An audience in a lecture hall is already interested enough to have made an effort to be present, they can see the speaker (which adds interest), and the speaker can see them and get their reaction and adjust his talk to their mood.

It is, therefore, best, in using radio to give a message, to make use of several voices. The different voices provide interest and change, and the audience gets the impression of being talked to rather than addressed.

Material for panel discussion (or for any other radio program) should always be prepared in advance. The master wits of "Information Please" are the only group of which I can think off-hand who have made a real success of an unprepared and unrehearsed program. A mike in a radio-station studio provides little inspiration, even for the most spontaneous after-dinner speaker or celebrated storyteller — Winston Churchill, your favourite news commentator, Jack Benny, Edgar Bergen, Fibber McGee all read from carefully prepared and carefully rehearsed scripts.

In preparing a discussion script, keep your cast small — three or four is a good number. This makes the script simpler and the program easier to follow. Start with an introduction by the announcer. Make your opening sentence as arresting as possible, but better not try any "stunts"! Have the announcer introduce the other participants, and have each one speak as his or her name is given, so that the audience can couple the name and the voice.

In writing radio scripts there is a form which has become standard because experience has proven it to be best—easiest for the actors and the studio engineers to follow. Write the name of the speaker in capital letters in the left-hand margin. Do not use this margin

for anything else. If you have any sound effects, treat "EFFECTS" as a speaker. When you want an effect, write "EF-FECTS" in the left-hand margin just as if "EFFECTS" were a member of the cast. Then write, in capital letters opposite, the effect you want. But beware of too many or too elaborate effects. If you have effects, you have to have a sound-effects man, which costs somebody money and which complicates your production and sometimes leads to difficulties even for professionals. If you need any effects, talk them over with whomever you are working at the radio station well in advance.

Make your dialogue conversational. Let it develop as it might develop if it were spontaneous. Say it over to yourself as you write it. If it doesn't sound natural, rewrite until it does.

Keep speeches short. The shorter the better.

If you have any special instructions for your characters, write them in capital letters and in brackets. For instance, you may want someone to read a certain line with particular emphasis. Write (WITH EMPHASIS) before the sentence. Then, when you want her to resume her normal voice, write (NORMAL VOICE). If you want a laugh or a sigh or a whistle, write it in the same way. It's as simple as that.

End your script with something interesting. Don't let it just peter out. Build up to something. In writing radio drama, we call it "the twist". You don't need a twist on an educational broadcast, but you do need a climax.

Bring the announcer back at the end of the script to tell the audience to whom they have been listening.

In writing a script, you need, roughly, one double-spaced typewritten 8-1/2

x 11 page for each minute on the air. But a lot depends on the type of the script and the cast. So rehearse it in advance, then add or cut as needed, and rehearse again until it is the right length. Keep within your time limit. Don't write quite enough to fill the time allotted to you — at the time of the actual broadcast someone may read more slowly than usual, and if you see your time slipping by too quickly you may get panicky. Better to be a little short.

Have the final scripts typed, doublespaced, on legal-size paper. Doublespacing means easier reading. And legalsize paper means fewer sheets to turn and rattle and perhaps misplace.

Don't break words at the end of a line of a radio script. This means a pause in the middle of the word while the reader's eye travels to the next line.

If you are acting as well as writing the script, remember this: Rehearse sufficiently. Become entirely familiar with your script. Underline words and make other notations which will help you. When rehearsing, practise holding and turning the pages of the script noiselessly. Try your voice in front of the mike before you go on the air, and have the studio engineers show you just where to stand or sit. Don't wander away from the mike or get too close to it during the broadcast. Speak in a conversational tone. Be quick on the pick-up. Be ready to come in as soon as the last word has left the preceding speaker's mouth unless the dialogue indicates a pause for thinking it over, but once you're started, speak a little more slowly than you ordinarily would.

You can get a lot of enjoyment out of radio writing or acting. And radio can do a big job for you.

Good luck!

Preview

What is the most up-to-date information regarding immunization? How much value is the inoculation against scarlet fever? Dr. Lawrence E. Ranta has prepared an authoritative statement for us which will be featured in December.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A.

Tuberculosis Affiliation in Saskatchewan

CHARLOTTE G. CROWE

The November, 1943, issue of The Canadian Nurse contained a short item under the caption "Who is to Nurse the Tuberculous Patient". Saskatchewan hopes to answer this challenge by providing aff.liation in tuberculosis nursing for student nurses. The results are immediate and long range; the student provides efficient nursing care while learning about tuberculosis; the graduate nurse will be better prepared to deal with tuberculosis when she meets it, and it is reasonable to suppose that more registered nurses will take up tuberculosis nursing after they have had an introduction to this fascinating and worthwhile field.

In setting up the present course the Saskatchewan Registered Nurses Association was approached by Dr. R. G. Ferguson, general superintendent of the Saskatchewan Anti-Tuberculosis League. A tentative curriculum was prepared and presented by the superintendent of nurses at Fort San to the superintendents of nurses of all the schools of nursing in Saskatchewan, to representatives of the Saskatchewan Registered Nurses Association and the Saskatchewan Anti-Tuberculosis League at three meetings held in different centres. A general meeting with the Council of the Saskatchewan Registered Nurses Association, held at a later date, passed the final curriculum and agreed to an eight weeks' course. The approval of the University of Saskatchewan was obtained and the affiliate school made subject to inspection by the Saskatchewan School of Nursing Adviser.

Contracts (as between the League and the Board of each hospital maintaining a school of nursing) were signed. These contracts include agreement of the School of Nursing Hospital to send a specified number of students (with specified basic nursing qualifications) every eight weeks and agreement of the League to provide the educational opportunities as outlined in the curriculum; to pay each student the same allowance as she receives in her home school; to pay transportation to and from the sanatorium and to provide sickness and accident insurance while the student is at the sanatorium. The first group of sixteen students registered at Fort San on June 1 and 4, 1945. By admitting on the two dates it is felt that the students will have more initial, individual attention and also that there will not be a complete change of students on one day at the end of each course.

The curriculum includes a total of thirty-five class hours, which covers lectures, demonstrations and medical conferences. The curriculum is flexible and can be adjusted to include material of special interest to the students. Each student prepares one case study which is



The first affiliate group.

presented as an oral report in a thirtyminute conference with the instructor and several staff members. The students are on a rotation service, that is, operating room, diet kitchen, pediatric, orthopedic and general wards.

The pediatric and orthopedic departments are two special services where the student nurse has an opportunity to observe the child who is not acutely ill but requires long term hospitalization and adults, who being orthopedic patients, present a problem not commonly encountered in general nursing.

The actual nursing of the tuberculous patient is not heavy. A properly followed routine is necessary but this does not in itself become monotonous as patients are sometimes in a sanatorium for years and it is part of the treatment not to let a routine become tedious to the patient. The psychology of nursing the tuberculous patient is different from that



The Infirmary at Fort San.

used in the nursing, for instance, of the very ill surgical patient. Often the tuberculous patient does not realize the extent of his physical disability nor what is necessary in the restriction of exercise for his complete recovery. It is all very interesting and the student who is successful in attaining a proper balance of sympathy and tact, plus an understanding of the patient's position, has gone a long way towards being able to handle the tuberculous patient.

Prevention of the disease is, of course, of vital importance. This phase of the work is also dealt with. Most of the student nurses have some knowledge of the effectiveness of B. C. G. vaccination and with further tuition and actual contact with the work being done, the follow-up work in the Districts will be better understood and the League will, therefore, get assistance in their surveys.

Before taking part in nursing at the sanatorium, the student has x-ray plates taken, blood counts, urinalysis and a physical examination by one of the medical staff. A check is also made before the student leaves the institution.

The students work an eight-hour day and a forty-eight hour week. They are assigned day and evening duty only, because it is felt that there are fewer educational opportunities on night duty. Class hours are included in "onduty" time.

The final grade received by each student is calculated from the scores received on special topics, case study and the final examination. The record returned to the student's home school includes a summary of her proficiency reports, a record of the types of cases nursed with the number of patient-days, the final grade and percentile ranking.

The eight weeks spent at Fort San do more for the student nurse than just introduce her to tuberculosis nursing. Of great importance is the change of environment. Situated, as it is, on the shores of Echo Lake, in the Qu'Appelle Valley, the spacious beautifully land-

scaped grounds are in contrast to most of our city hospitals. The student has the benefit derived from associating with nurses from other schools of nursing and she has the opportunity to learn to adjust to a new situation where not only techniques but policies, too, are different.

The social life of the student is not forgotten. There are many seasonal sports such as: tennis, swimming, skating. There is a movie once a week. Picnicking is popular and the dietitian is always ready to be of assistance in planning an outing of this sort.

Standards of nursing that were rigidly maintained heretofore, and have unavoidably been lowered on account of lack of properly trained personnel, are being brought back to their former level and this first group of affiliate students will go down in history as having made a valuable contribution in assisting to make this possible. We realize that the success of the affiliate course will be determined by the results obtained and it will be interesting to note how the students react to this type of work when they leave their schools of nursing.

The Welfare of the Generation

The welfare of the growing generation, the creation of all conditions necessary for the upbringing of healthy, happy and well-educated citizens, has been the special care of the Soviet Government from the very first days of its rule.

No country in the world has such a wideflung network of children's institutions as the Soviet Union. Nurseries, kindergartens, boarding schools, schools and children's clinics and hospitals were opened in all cities and villages, in the most remote corners of our vast country.

In the grim years of the war the Soviet Government has devoted particular attention to the younger generation. During the first stage of the war, tens of thousands of children were evacuated to the eastern regions of the country and the necessary measures were immediately taken to ensure qualified medical attention for these youngsters. The fulfilment of these government decisions was laid upon the People's Commissariat of Public Health which at once made preparations for the opening of additional consultation centres, polyclinics, hospitals and children's homes.

A pasticularly great increase has taken place in the number of nurseries existing in the RSFSR since the war began. Whereas there were 2,797 permanent nurseries with

162,940 cots in the thirty-six regions of the republic on January 1, 1941, by 1944 the permanent nurseries were able to accommodate 507,000 children and this year this number will be increased to 634,000.

Particularly wide-scale work in this direction has been carried out by the public health organizations in the villages and in the outlying regions of the Soviet Union. During these years 55,465 cots were added to the nurseries in rural regions, this being 44 per cent of the prewar number.



The "Molodaya Gvardia" Children's Home — The children listen to a fairy tale told by their teacher.



The children study music.



Dinner-time.

As millions of women went to work in factories and plants, the brunt of the care for the health and welfare of their children was laid upon the shoulders of the nursery personnel, and many improvements were made in the care of the babies and special sections for sick children were opened in all nurseries, which greatly eased the life of the mothers.

However, the organization of new nurseries did not exhaust the scope of the measures taken for maternity and child welfare. Since the war broke out, no less attention has been paid to the formation of new consultation centres and polyclinics for children. In peace-time the RSFSR had some sixteen hundred consultation centres for mothers and children. In the course of the first two years of the war this number had grown to 1,756 and is steadily increasing; it is scheduled to reach 3,374 in 1945. This growth is particularly noticeable in certain regions. For instance, 99 new consultation centres, of which 77 are in remote villages, have been opened in the Urals and in Siberia,

A radical change has also taken place in the nature of the work itself. Every one of them now has a staff of highly qualified doctors, nurses and health visitors. Particular attention is paid to weak and backward children who are kept under special observation and receive increased rations, cod liver oil, electric treatment and so forth.

It is natural that the war should have caused certain difficulties with the supply of provisions and other articles of prime necessity but, thanks to the tireless efforts of the Government, this has in no wise touched the children. The increase in the number of milk distributing centres is characteristic in this respect. In 1940 these centres distributed some 80,000 portions, and during the past year the children received about 186,000 portions of excellent milk in spite of the fact that the livestock breeding regions of the country had been decreased as the result of the temporary occupation.

At the same time, a considerable increase has taken place in the number of children's homes. In 1941, about 6,568 children were being brought up in these homes, and at present 25,000 children of servicemen are being maintained in like institutions.

In order to improve the food supply for children a decision was passed to provide the children's institutions in the city of Vladivostok with additional provisions to the sum of 308,000 rubles — 2,602 kg. of chocolate, 50,000 cans of condensed milk and so forth. Similar measures were taken in other regions of the country. Also, in the majority of autonomous republics, regions and districts, special subsidiary farms were formed, the products from which went to improve the children's diet. The Khabarovsk regional executive committee has given the children's institutions 150 cows; Kalinin Region — 120 cows, and so on.

For older children a large number of special dining-rooms, catering to 295,000 young-sters, were opened. At present, there are no regions or districts in which such dining-rooms do not exist, the majority of them catering to children of servicemen.

N. Manannikova Assistant People's Commissar of Public Health of the RSFSR.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

Placement Bureaux Institute

An institute for directors of Nurse Placement Bureaux, the first in Canada under the auspices of the Canadian Nurses Association, was held September 5-15, at the University of Manitoba, Winnipeg, with representatives from eight provinces present.

Dr. Frances Triggs, Ph.D., personnel consultant of the American Nurses Association, was guest lecturer. The first five days were devoted to group discussion and the last five days to consideration of personnel management problems. The meetings, September 10-15, were open to administrators of hospitals and public health organizations, and to nurses who were especially interested in personnel work.

A complete report of this institute will appear in a later issue of *The Canadian Nurse*.

Youth Training Plan

Due to the fact that we have received so many inquiries about the Youth Training Plan from various provinces, we decided to write to each Registered Nurses Association to find out which provinces were receiving benefits for student nurses. The replies were as follows:

Alberta: Dominion-provincial financial aid is now available in an amount of one hundred dollars each to girls of eighteen years and over who are interested in nursing as a vocation, but whose parents are unable to finance the three years training period. This grant does not have to be repaid. Fifty dollars will be paid after the student has been definitely accepted by a school of nursing and fifty dollars on successful completion of the preliminary term of approximately four months. The grant will be restricted to those who sign the agreement that they will make their services available as nurses on graduation, either by enlisting in the armed forces or by nursing in a war industry, hospital or similar public institution, or in departments of public health.

British Columbia: The provincial Department of Education allocated \$2,000 of Dominion-Provincial Youth Training Plan Fund for bursaries for student nurses in 1944-45 and \$3,000 for the current fiscal year. The entire amount was used last year, and many requests are being made for bursaries for this year.

Manitoba: 1. The purpose of the loan fund is to assist nurses in training, who, without financial assistance, could not enter on or continue their training.

- 2. All trainees must sign an agreement that, upon graduation, they will serve as nurses in the armed forces, war industries, public health work, approved hospitals or similar government institutions.
- 3. The maximum loan to any student shall be two hundred dollars per training year.

- 4. Assistance shall be given in the first instance as a loan, but one hundred dollars of such loan shall be cancelled for one year's service, as designated in Regulation No. 2, and fifty dollars additional for each additional six months service.
- 5. Any trainee who breaks the agreement designated in Regulation No. 2 (except for reasons beyond her control) shall immediately be required to repay the loan in full, with interest at the current rate.
- 6. If granted a loan, the applicant shall sign a promissory note for the amount of the loan, payable to the Province of Manitoba, Department of Education, Canadian Vocational Training Branch, and may be required to provide security.
- 7. In the event of a loan being granted to a minor, the promissory note which she signs must also be signed by a person meeting the approval of the Loan Committee.

New Brunswick: No provision has been made for student nurses in New Brunswick through the Youth Training Plan.

Nova Scotia: There are no grants for nurses under the Youth Training Plan. This is to be brought to the attention of the executive of the provincial Registered Nurses Association at their next meeting.

Ontario: Up to the present the Ontario Government has not participated in the Dominion-Provincial Youth Training Plan. No subsidies have been available from this source for student nurses. It is the intention of the Registered Nurses Association of Ontario to make inquiries as to the attitude of the present Government in this matter.

Prince Edward Island: No grants for nurses under the Youth Training Plan.

Quebec: Bursaries are available for students attending provincial universities in any year or in any faculty. The maximum of these scholarships is three hundred dollars, 50 per cent of which is given as a grant and 50 per cent as a loan, repayable one year after the student has left the university.

Nurses taking courses in approved hospitals may also benefit by the annual scholarships of one hundred dollars given as a full grant, provided they agree not to engage in private service for a year after graduation.

A report from Miss Upton, executive secretary, Registered Nurses Association of the Province of Quebec, states that since 1943, when student nurses were first included in the plan, more than five hundred students have received financial assistance from the fund created by federal-provincial co-operation. The Committee of Management, R.N.A.P.Q., recommends a continuance of the Youth Training Plan as applied to student nurses.

Saskatchewan: The maximum assistance available is one hundred dollars per year. In order to receive a second or third grant, it is necessary to submit a request for it, together with an affidavit from the parent or guardian covering his present financial position, and a letter of recommendation from the director of nursing. All applications go through the registrar of the Saskatchewan Registered Nurses Association.

In a letter received recently from Mr. R. F. Thompson, Director of Training, Department of Labour, Canadian Vocational Training, the following appears: "Student aid schedules are in effect between this department and all provinces, but assistance to nurses is only provided for in the province of Quebec and the four western provinces. Such assistance was evidently not considered necessary in the Maritimes or in Ontario, as no request was made to us for those provinces to include nurses within the provisions of our schedule."

Canadian Hospital Council

The Canadian Nurses Association was represented at this meeting in Ha-

milton on September 19-21, 1945, by the president, Miss F. Munroe, and Miss Winnifred M. Cooke, assistant secretary.

The chief topics on the agenda were (1) the personnel situation; (2) pensions for hospital employees; (3) rehabilitation of demobilized men and women; (4) training of hospital administrators; (5) hospital construction; (6) hospital finance; (7) health insurance.

Of particular interest to nurses was the report of the Committee on Nursing and Nurse Education presented by the chairman, Miss Blanche Anderson, assistant director of nursing, Ottawa Civic Hospital. Other members of this committee are as follows: Sister Anna, All Saint's Hospital, Springhill, N.S.; Marion Myers, instructor of nurses, Saint John General Hospital, N.B.; Rev. Sister Madeleine de Jesus, chairman, Council on Nursing Education in Canada, Catholic Hospital Association, c/o University of Ottawa School of Nursing; Frances Upton, registrar, Registered Nurses Association of the Province of Quebec, Montreal; Rev. Sister M. Magdalen, registrar, Prince Edward Island Registered Nurses Association, Charlottetown; Rev. Sister Delia Clermont, St. Boniface Hospital, Man.; Kathleen W. Ellis, registrar and inspector of nursing schools, University of Saskatchewan, Saskatoon; Margaret Fraser, superintendent of nurses, Royal Alexandra Hospital, Edmonton, Alta.; Catherine M. Clibborn, assistant director of nurses, Vancouver General Hospital, B. C.

A request was made that the future chairmen of this committee be granted the privilege of attending the executive meetings of the Canadian Nurses Association, so as to be able to interpret nursing, on a national basis, to the Canadian Hospital Council. Whatever affects nurses or nursing very definitely affects hospitals, and, therefore, should

be of interest to the Canadian Hospital

Miss Anderson indicated in her address that the present situation in nursing shows that the nursing personnel in hospitals and in other fields of nursing has faced with increasing difficulties the problem of meeting the need of the essentials of good nursing care. The unessentials have been reduced, nursing procedures simplified, and the work carried on with a degree of efficiency that has earned sympathetic understanding of nursing problems on the part of hospitals, doctors and the citizens of Canada. The weakness of the graduate staff nurse is her inexperience and her lack of preparation. There has been a marked decrease in the number of general duty nurses during 1944-45. Some of the reasons given were: (1) The appeal of change of work and different environment; (2) lesser responsibility; (3) easier hours of duty; (4) salaries which are higher.

The number of student nurses increased slightly in 1944. Clinical facilities in special services, teaching and supervisory staff, as well as living accommodation, have been stretched to a point at which further increase is undesirable until adjustments can be made.

It was felt by all members present that nursing education should receive the financial support of the Government, as do all other branches of education. Nursing service is essential to any community.

Tribute was paid to the married nurse and to the nurse who had come from retirement back into the field of nursing to render service during the war years.

It was suggested that the Government be asked to delay the educational and financial benefits for military nurses for two or three years, so that they could help out in the present hospital situation.

The domestic staff was a problem with which all hospitals were faced, and no solution found.

The overcrowding of hosp tals which has been continuous, is one of the most trying difficulties with which nurses are faced. This results in decreased working space, increased physical effort, is uneconomical of time, defeats interest and pride in a finished piece of work, and is unhygienic for patient, nurse and other workers. Good bedside nursing cannot be carried out under such conditions.

The future makes many demands upon nurses: (a) Publicity campaign to bring before the minds of the public the essential value of nursing service. (b) If an adequate flow of students into our schools of nursing is to be maintained, it is necessary that nursing education, conditions of employment, and financial returns compare favourably with other employment of comparable requirements and responsibilities. A public health nurse with postgraduate university course should be found on the staff of every general hospital, to interpret commun'ty health to staff and patients. Legislation should be secured for the preparation and licensing of all subsidiary workers. If these workers are introduced into hospitals, it will necessitate increased supervision and responsibility for the graduate staff.

The maintenance of a satisfactory staff is paramount. There should be provision for leave, with salary and expenses, for attendance at nurses' conventions; for refresher courses; observation periods at other institutions, and for long and short-term bursaries for clinical and university courses; some inter-hospital government annuity or a contributory pension scheme similar to that recently established for the Victor an Order of Nurses; the advisability of having capable nurse administra-

tors to act in a technical, advisory capacity, to strengthen the building committee of hospital construction—many omissions and inconveniences would thus undoubtedly be avoided.

The post-graduate courses in universities and courses available in hospital schools and added experience arrangements in hospitals were all listed in *The Canadian Nurse*. See the July, 1945, issue for details.

Other activities and interests mentioned in the report were as follows:
(1) Affiliations in tuberculosis nursing;
(2) placement bureaux; (3) UNRRA;
(4) the brochure for the returned nursing sisters; (5) labour relations; (6) masks; (7) labour exit permits.

No doubt this paper will be printed in detail in the *Canadian Hospital* magazine. We would advise all nurses to read and study the report in detail, and suggest that it may be used for group study within the next few months.

Reprints

In response to an unexpected demand for copies of the articles in the series "Nursing and National Health" which recently appeared in newspapers across Canada, we have had these articles bound in a booklet. Copies are now available at National Office at forty cents per copy.

A third in the series "Discussion on Nursing" is now ready for distribution. These scripts are prepared for "live air" on the radio, but we were very much interested to learn that they have been adapted on several occasions for use over imitation microphones in high school and nursing school auditoria. We think this suggestion worthwhile passing on.

White, for years the standard paint for hospitals, is giving way rapidly to soft tints, even in the operating rooms. The softer tones eliminate glare and give a light which is easier on the eyes of patients and attendants, with a consequent boost to morale.

Nursing Education

Contributed by

COMMITTEE ON NURSING EDUCATION OF THE CANADIAN NURSES ASS'N.

Proposed Changes in the Preparation for Nursing

Examining the proposals

In June, 1944, certain proposals concerning nursing education were made. To many nurses, these proposals were not really new or particularly startling: to others, they seemed radical and disturbing.

We may assume that in a democracy anyone has a right to make a suggestion, and that anyone else has a right to question it. But we also think it may be assumed that nurses in good standing who make serious proposals to the Canadian Nurses Association do so in good faith and in what they conceive to be the interests of nursing: and we believe that those who object to the proposals should examine them carefully and make quite sure what is being proposed. The proposers should not be accused, instantly and automatically, of being willing to "lower the standards of nursing." Incidentally, more than one member of the public has suggested recently that professional standards are sometimes invoked more in the interests of the profession than of the public. Unwarranted assumptions from a proposed plan do not help the cause of nursing.

Developments in other countries

It may help to secure a calm and reasoned consideration of the possibility of change in our nursing system if we realize that similar suggestions are being made in other countries, and that in fact some of these countries have taken action on them, and are trying out, in various forms, experiments to try to meet the nursing needs of these coun-

tries. In England an assistant nurse is now recognized by law, a course of training of two years is outlined, and the rules for admitting these nurses to the register of the General Nursing Council are now being drafted. Incidentally, it is proposed to teach a much greater number of somewhat advanced nursing techniques to this person than have ever been proposed for our assistant nurse.

In New York, the Practice Act provides for the training and licensing of practical nurses as well as professional nurses.

In India, during the years of the war, 3500 auxiliary nurses have been trained, and will now be available for civilian hospitals.

New Zealand in 1939 passed an amendment to the Nurses and Midwives Act, providing for the training and registration of nursing aides. The period of training is two years, followed by a state examination.

Fuller accounts of these experiments will be found in the nursing journals of the countries concerned. The point is that various countries recognize the need for change, and that some have not been afraid to try out new methods. Here, though the nursing profession hesitates to admit it, we are actually producing and using at least three kinds of nurse, but we are doing so in an unplanned and haphazard way.

Choosing the type of nursing preparation

It has been suggested (and much controversy has followed the suggestion)

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that two types of professional preparation should be made available. One, the short course, perhaps two years in length, would prepare, as simply as possible, a skilled clinical (and registered) nurse; the other, four years in length, would give just as thorough a clinical training, but would do this as part of a much broader educational content, so that the foundation would be laid which would enable this nurse to progress to the teaching ranks of the profession. Here the word 'teaching' is used in a broad sense to include public health nursing as well as the teaching and administrative work in hospital nursing.

It has been asked how a young woman is to know whether she wants a clinical or a clinical-teaching preparation. Unfortunately, young people leaving high school do not always know definitely what they want to do, but a choice has to be made. If the choice is wrong, then it is a matter either of abiding by it, or of starting afresh. Many women who have prepared for teaching later turn to nursing, and take the complete preparation for it. The occasional nurse decides that she should have gone into medicine, and does not question the necessity for taking the medical course. As personal and vocational counselling services develop in high schools, girls will be better equipped to choose their professions. On the other hand, many young women would experience no difficulty at all in deciding on which type of nursing preparation they wanted.

It has also been asked why it would not be possible to arrange the shorter and the longer preparations in such a way that a person who had had the simpler clinical course could later transfer, and in say two additional years, complete the longer course. The answer is simply that the two would be different from the beginning. The four-year preparation would have to be given in a university and would include a much more extensive foundation in sciences and public health; and these, with certain other subjects, are the reason for the greater length of the course. Thus it would not be a question of simply adding on certain things to the shorter preparation; the two courses, being for different purposes, are different throughout; and the decision as to which is desired would have to be made at the beginning. However, with the expectation that some nurses would wish to step across from the junior to the senior group, (providing they had the necessary entrance requirements for university work), it is reasonable to assume that some allowance of time could be made upon their behalf.

Our next article will discuss the question: "Would the 'teaching nurse' be able to nurse patients?"

Finding Orthopedic Defects Important

Every child discovered to have any orthopedic defect, no matter how slight, should be considered a potential cripple and every effort should be expended to alleviate or control the condition. It is during the school age period that good posture habits can be effectively established and existing orthopedic deviations readily corrected, thus ensuring a healthier, happier adult life.

The teacher, through her daily association with the children, is in an excellent position to render a very valuable service in such a program. If the school nurse will see that the teachers are given an understanding of the problem and the part they can play in helping to solve it, she will be more than

repaid by their contribution . . . the teachers can be urged to be on the alert for any limps, peculiar gaits, abnormal function of the arms and hands, habitually poor posture, tendency toward fatigue, and any other conditions that show deviations from the normal functioning of the body.

An examination by the orthopedic surgeon will determine whether these postural deviations are functional and can be corrected by the application of exercise therapy and other simple corrective measures; or whether the condition is structural.

—Abstract from E. M. Johnson, Public Health Nursing, 1945, Vol. 37: 472.

Interesting People

Margaret O. Cogswell, B.A., graduate of the school of nursing of the Royal Victoria Hospital, Montreal, has recently been appointed as the director of the newly organized Nurse Placement Bureau with the Alberta Association of Registered Nurses.

Miss Cogswell has the breadth of background which is so essential in a vocational counsellor. Prior to entering her school of nursing, she had useful experience as a high school teacher. After two vears' service as head nurse on a men's medical ward at the Royal Victoria Hospital, Miss Cogswell received her training in public health nursing at the Mc-Gill School for Graduate Nurses. Following a brief period of relief work with the Alberta Department of Health, she returned to hospital administration at the Royal Alexandra Hospital, Edmonton. For the past year she has been head of the teaching department and science instructor at R.A.H. To round out her experience before assuming her new duties, Miss Cogswell is serving as a general staff nurse in a small community hospital. She has done excellent work throughout and understands the problems of both the hospital administrators and the staff nurses. Miss Cogswell has the happy faculty of being able to see the other person's point of view and of assessing difficulties fairly and honestly. These qualities, combined with her natural diplomacy, and all well mingled with a sense of humour, augurs well for the success of the new placement and counselling service.

The Victorian Order of Nurses for Canada has been pleased to announce the appointment of Esther Robertson as national supervisor of the Western branches. A graduate of the school of nursing of the Royal Victoria Hospital, Montreal, and of the public health nursing course, McGill School for Graduate Nurses, Miss Robertson has taken further post-graduate study at Teachers College, Columbia University, during recent summer sessions.

Miss Robertson has been a member of the Montreal staff of the V.O.N. for the past nine years and since 1941 has been the supervising nurse of the North District. Keenly interested in professional problems, she has served on many committees, and, like most truly busy people, always finds time to do all the extra things asked of her. We know that her many friends and associates will regret



MARGARET O. COGSWELL



Esther Robertson



FRANCES H. WAUGH

her leaving Montreal, but we are sure a warm welcome awaits her in the West. Our very best wishes go with Miss Robertson for success and happiness in

her new work.

New developments create new opportunities for nurses. With the passing of the Act for the training, licensing and regulation of practical nurses in Manitoba, Frances H. Waugh relinquished her position as assistant to the executive secretary of the Manitoba Association of Registered Nurses to become the first registrar and consultant for the practical nurses under the Department of Health and Public Welfare.



Little Studio, London

CORA M. BROOKS

After securing her arts degree at the University of Manitoba, Miss Waugh graduated from the school of nursing of the Winnipeg General Hospital. After a post-graduate course and a year's experience in surgery, Miss Waugh further prepared herself by taking the course in teaching and supervision in schools of nursing at the University of Minnesota, following which she served as instructor with the schools of nursing in Portage la Prairie and Grace Hospitals. The new development under Miss Waugh's guidance will be watched with keenest interest.

Helen Estelle Schurman, who for the past fifteen years has held the position of university nurse at Acadia University, Wolfville, N.S. has recently been appointed superint indent of nurses at Eastern Kings Memorial Hospital in Wolfville. A graduate of Acadia University and of the school of nursing of the Royal Victoria Hospital, Montreal, Miss Schurman took her public health nurse's training at the University of Toronto. She has shown outstanding ability in her health program with the hundreds of students at Acadia and is highly regarded by her townsfolk in Wolfville.

Gladys Tanner has been appointed superintendent of the Kincardine (Ontario) Hospital after serving for five years as assistant superintendent. A graduate of the school of nursing of the Brantford General Hospital, Miss Tanner did private duty nursing before joining the staff of the Kincardine Hospital.

Cora Marcella Brooks, who served in Newfoundland as a nursing sister with the Royal Canadian Navy, has been appointed as director of nursing education at the General and Marine Hospital, Owen Sound, Ont. Miss Brooks, who graduated from the Woodstock General Hospital, winning the Dunlop award, has had a wide experience in nursing. After several years of private duty and work with pediatricians as nurse assistant, she took post-graduate work in surgery at Johns Hopkins Hospital, Baltimore. She received her certificate as instructor of nursing at the University of Western

Ontario, London, Ont. She served in the operating theatre at the Victoria Hospital, London, and at Queen Alexandra Sanatorium, Byron, immediately prior to her new appointment.

Miss Brooks has been very active as an instructor with the Canadian Red Cross Society both before and during the war.

Zeta Hamilton has been appointed as the new superintendent of the hospital at Galt, Ont. Previously, Miss Hamilton had successfully administered the school of nursing at the Stratford General Hospital for sixteen years.

Mrs. Lennie E. MacPherson has assumed the duties of acting superintendent of nurses at the Nova Scotia Sanatorium in Kentville after serving on the staff of the Toronto Hospital for the treatment of tuberculosis in Weston, Ont. Mrs. MacPherson has had broad experience in a variety of hospitals in United States and Canada.

After almost ten years of efficient service as superintendent of nurses at Falconwood Hospital, P.E.I., Mrs. Ruth (Rayner) Dignan has resigned. Her place is being filled temporarily by Mrs. Esther Sellers, who for the past few years has been on the staff of the Montreal Convalescent Hospital and the Provincial Sanatorium in Charlottetown.

Isabel Davies, A.R.R.C., has retired from active hospital duties. Miss Davies has been supervisor of the operating rooms of the Montreal General Hospital since her return from overseas and retirement from the R.C.A.M.C. in 1919.

Upon her graduation from the M.G.H. School for Nurses in 1908, Miss Davies joined the hospital's nursing staff as an assistant in the operating room, a position she held continuously until 1915, except for a short period in 1913 when she took up private duty nursing. When No. 3 (McGill) General Hospital was organized in 1915, Miss Davies was invited to take charge of the operating room and proceeded overseas with this unit as part of the Canadian Expeditionary Force. Miss Davies remained with that hospital



Clara E. Jackson christens the H. M. S.
Rosamond.

until its return to Canada in 1918, when she continued her military service as supervisor of the operating room at Ste. Anne's Military Hospital. For the conspicuous services Miss Davies rendered during her period of military service she received the decoration of an Associate of the Royal Red Cross.

In presenting Miss Davies with a purse containing Victory Bonds as a gift from the present members of the Consulting and Attending Staffs, Dr. J. Guy W. Johnson paid high tribute to Miss Davies' efficiency and the outstanding and loyal service she has given to the hospital over a period of many years. Some three hundred guests were present to extend their best wishes for the future to Miss Davies.

Capt. (Matron) Cecil M. MacDonald, A.R.R.C., who has recently returned from four years service in England, Italy and the North Western European theatre of operations, has been appointed to fill the vacancy created by the retirement of Miss Davies.

A unique honour came to a well-known nurse recently when to Clara E. Jackson, superintendent of nurses at the General and Marine Hospital, Collingwood, Ont., came the privilege of christening a new naval vessel, the H.M.S. Rosamond.

Nancy Dunn, M.B.E., who pioneered in the development of public health nursing in the Peace River area in British Columbia, has launched on another adventure by taking over the supervision of the health of the citizens in Telegraph Creek, Northern B.C. Her territory covers nearly three hundred square miles, the remote settlements of which can only be reached by dogteam and plane. Since the nearest doctors are some two hundred miles away, Miss Dunn has recently completed special post-graduate courses in Vancouver and Victoria to fit her for any and every eventuality.

Obituaries

Beatrice Eileen Cryderman died recently in Bowmanville, Ont. A graduate in 1930 of the school of nursing of the Toronto General Hospital, Miss Cryderman had been engaged in public health nursing in Toronto.

Agnes Findlay died recently in Toronto. Miss Findlay graduated from the Presbyterian Hospital, New York, in 1906. She has resided in Toronto since her retirement from active work in 1938.

Agnes Lee Inkster died recently at

Salmon Arm, B.C. Member of a pioneer Manitoba family, Miss Inkster was a graduate of one of the first nursing classes of the Winnipeg General Hospital. After her graduation she served for a time as matron of the Lady Minto Hospital at Rat Portage. In 1909 she moved to Salmon Arm where she spent the rest of her life in service to her fellows.

Margaret (MacKay) Wall died recently in Vancouver. Born in Scotland, Mrs. Wall received her training in Manchester, England. She served overseas in World War I and later nursed at Hartney, Man.

Geriatrics

Probably the greatest changes in hospital planning have to do with the field of geriatrics. The progress of medical science is throwing not hundreds or thousands but literally millions of people into the age group in which the principal diseases are those of senescence and decline. During the last decade these patients have been classified as uninteresting cases or not eligible for hospital care. In the future it will be important that hospitals consider their proper responsibilities as centres for the care and rehabilitation of these patients.

The day of the home for incurables is past. The day of the rehabilitation centre is dawning. In addition to careful medical supervision, all too often lacking in the past, hospitals must plan for greatly increased

facilities for occupational therapy, which is the key to the care of these people.

A longshoreman who has outlived his vocation may quite easily be shunted to a bed as an invalid for the rest of his life. With proper application of occupational therapy methods it is perfectly possible to develop in the same person an entirely new attitude toward a new occupation which will convert him from a chronic invalid to a self-supporting and useful citizen.

The requirements are planning, personnel and understanding of the problems involved. The convalescent pavilion or rehabilitation unit should be a part of every hospital that is attempting to do its full job for its community.

-The Modern Hospital.

Preview

Turning every possible opportunity into a learning experience for the student is an old story to the good clinical instructor. A patient with a paralyzed bladder provided the material not only for the teaching of actual techniques but

also for very much more in understanding of the patient when Clara R. Aitkenhead taught her pupils the care of the case which Dr. S. A. MacDonald will describe for us. Watch for both of these interesting articles in the December issue.

STUDENT NURSES PAGE

St. Paul's Goes Recruiting

ANN BEECHINOR

Student Nurse

School of Nursing, St. Paul's Hospital, Saskatoon

Under the auspices of the Alumnae Association of St. Paul's Hospital, Saskatoon, an interesting function in the form of a publicity program was held recently at the nurses residence, when the graduating classes of all the city collegiates were invited to come and pay a visit to our hospital.

Guided by the members of the Alumnae, the high school girls toured the hospital, the medical and surgical wards, as well as the special departments, in order to give them an idea of the everyday life of a nurse in her actual bedside nursing. Then the girls were taken through the spacious residence where they saw the lovely bedrooms, beautiful reception rooms, the library and study rooms all with the comfortable and home-like atmosphere. It amused the girls to see the brightly-coloured array of articles in each nurse's room, and the pennants, all of which are very precious to each nurse because of their connection with home.

Later, an enjoyable get-together was held in the auditorium. A short program consisting of a few musical selections along with some interesting talks were given by the members of the school of nursing. Capably conducted by Miss Marvalon Robinson, the Alumnae president, the program opened with a stimulating talk by Miss Velma MacDonald, a freshman student. Miss MacDonald

outlined in general the three years course, indicating the advance in learning and work through freshman, junior and senior years. She spoke of the wide field of opportunity which lay open to a graduate at the end of her course. Miss Ann Beechinor, a junior student, then gave a more informal account of an average nurse's day, from the sound of the sixthirty buzzer in the morning to the clang of the ten-thirty bell at night. She showed that, though it is a busy life, it is full of interest and enjoyment.

On behalf of the graduating class, Miss Wensley told her audience that, "Although the road be long and rough, there is at the end the happiness of knowing my duty is well done". The classes every day, the clinical work, the joys and the sorrows that constitute the life of a nurse seem to balance themselves at the end of the road. Despite the difficulties and misfortunes, the speaker stated emphatically, "I would do it again, anytime". Miss Eleanor Pfeiffer, a student of the combined studies, explained the university course in nursing as carried out in Saskatchewan, and informed the girls how to enrol in such a course. The hospital which the student selects provides the professional and clinical aspect, while the university is responsible for the academic studies and the conferring of degrees. At the completion of this five years, a nurse is en-

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titled to the degree of Bachelor of Science in Nursing.

Tea was served after the program, during which the student nurses chatted informally with the collegiate girls.

The afternoon proved a success for

the girls were well pleased with their visit to the hospital. Any bystander could overhear them saying to one another, "You know, after what I saw this afternoon, I think that I would really like to be a nurse".

Book Reviews

Personnel Work in Schools of Nursing, by Frances O. Triggs, Ph.D. 237 pages. Published by W. B. Saunders Co., Philadelphia. Canadian agents: Mc-Ainsh & Co. Ltd., 388 Yonge St., Toronto 1. 1st Ed. 1945. Illustrated. Price \$3.25.

Reviewed by Kathleen Mary Stanton, R.N., B.Sc., Lecturer, McGill School for Graduate Nurses.

This book should be most instructive for those who teach and supervise student nurses both in the class-room and on the wards. It is generally recognized in modern educational practice that teaching is essentially a process of stimulation and guidance through which the student learns and this book is an exposition of this fundamental process. Dr. Triggs realized the need for such a book because she possesses the attribute of caring how workers and learners develop and especially the student nurse. Therefore, this publication should be a most valuable tool in the hands of those who are responsible for the professional growth of the student nurse.

The book is divided into four parts: Part 1 reviews the fields of psychology and physiology very briefly, assuming that most instructors in schools of nursing have had some background in these subjects. The author places special emphasis upon the sympathetic relationship between the student and the counsellor as an essential factor in effective counselling.

Part 2 outlines the qualifications of the counsellor. It also deals with the counselling program and presents concretely the problems that the student nurse has to face, treated under specific situations. A final application is made separately to each of the various aspects of counselling, namely, educational, vocational and personal.

Part 3 deals with tests. This portion of the book should be particularly helpful to teachers and supervisors who have not made a special study of the purpose of testing and types of tests that are now being used in the field of professional education.

Part 4 brings the content of the book to a focus by making personal application to the "Story of a Student".

The book has added merit in that each chapter is supplemented with excellent reference books by outstanding authors, including: Sandiford, Peter: Foundations of Educational Psychology; Shaffer, Laurance Frederic: The Psychology of Adjustment; Strang, Ruth: Behaviour, and Background of Students in College and Secondary School.

A carefully selected bibliography on personnel work in schools of nursing is listed at the end of the book.

This text is not highly technical; its merit lies in the fact that it can be used as a practical medium by all superintendents of nurses in interpreting the purpose and scope of a program of educational guidance in schools of nursing upon which sound planning can be based.

Public Health and Welfare Reorganization in Canada, by Harry M. Cassidy, Ph.D. 464 pages. Published by The Ryerson Press, 299 Queen St. W., Toronto 2B. 1st Ed. 1945. Price—paper bound, \$3.50; cloth bound, \$4.50.

A companion volume to his Social Security and Reconstruction, Dr. Cassidy states his purpose here is "to analyse the problem of reorganizing and developing the provincial and local health and welfare services so as to fit them into a national plan of social security". He predicts that "drastic changes in organization and administration are required before the provincial and local social services in Canada can reach high standards".

In outlining the premises for provincial planning, Dr. Cassidy summarizes the proposals contained in the four national plans which have been submitted to date — the Marsh plan, the Heagerty report, Miss Whitton's proposals and his own suggestions — and points out similarities and differences.

Part 2 describes in detail the developments which have taken place in British Columbia, which Dr. Cassidy credits with being "progressive as compared with others (provinces) at least in Canada". Part 3 outlines the status of the health and welfare services in the other provinces. Part 4 points to "The Road Forward". Here the major flaws in the present systems are delineated and corrective measures suggested.

The data which this book contains are very well worth the careful study of everyone concerned with health and welfare practices. It should be a "must have" in every public health organization library.

New Steps in Public Health — twentysecond annual conference of the Milbank Memorial Fund, April, 1944. 148 pages. Published by the Milbank Memorial Fund, New York. 1945.

Reviewed by Helen G. McArthur, Superintendent, Public Health Nursing Branch, Department of Public Health. Alberta.

If public health workers are tempted to feel satisfied with their accomplishments and procedures, or, on the other hand, feel they are lost in a maze of problems with no sign-posts to guide them ahead, here is a book that should help shatter these states of mind. The volume contains twelve papers prepared by outstanding American public health authorities and one Canadian, Dr. F. F. Tisdall of the University of Toronto Medical School.

Seven of the papers are in the field of nutrition, expressing not only our growing realization that nutrition deserves a place of major importance in our public health and medical programs, but indicating that research in this field is giving us many guides for more effective public health work. Of particular interest are the papers "The Importance of Prenatal Diet" and "Nutrition — Its Place in our Prenatal Care Programs" as well as the papers on "Industrial Health and Nutrition."

The description of the Peckham Experiment gives a practical demonstration of how our public health horizons could be broadened. "The Peckham Experiment was indeed a study of living structure of society by physicians trained in social medicine and human biology."

Some of the papers hit hard! G. St. J. Perrott, chief, Division of Public Health Methods, U. S. Public Health Service, says, "Since the time of Civil War the high proportion of physical defects found among young men being examined for military service has been viewed with alarm. The only result observable in eighty years, however, has been a number of papers by medical statisticians. It is hoped that the present results will draw the attention of others than statisticians and serve to promote the planning of more adequate health services for children and adolescents so that young men and women of future generations may achieve a maximum level of good health."

The paper "More Adequate Provision and Better Integration of Community Facilities" discusses some of the emerging concepts in the public health field that give new hope that we really can get somewhere. Public health workers reading these papers cannot help but be inspired to get at the job and try again.

Letter to the Editor

Excitement in Halifax

The sea was so calm that a sailboat, trying to induce a fleeting breeze to take it for a jaunt, was having no success. An R.C.A.F. shore boat, whizzing by, made it bob up and down like a cork. The water looked peaceful with lovely each smooth ripple, and the setting sun threw its colours around, to be tossed off by the water in a gay swirl. The blue sky, decorated with white puffy clouds, made a beautiful back-drop and all was peace. Yes, it was all very lovely as we watched the usual activity of a busy harbour - and destruction, if we thought about it at all, seemed very far away and unreal.

A game of cribbage out on deck had been stimulating, even though I confess to having been "skunked", and I was just about to start in anew with optimism when suddenly a deafening noise interrupted the pressure in my ears and made me gulp. The ship shivered and with one leap we were all rushing aft to see what had happened.

A colossal column of smoke, black and curling, was rising into the air about seven miles away as the crow flies, over near Bedford Basin. We watched its ascent, fascinated, and began to speculate about its cause. It could be oil, we thought aloud; it could be ammunition, someone opined; and yet, there seemed to be no aftermath — there seemed to be no more smoke — curious — and we all thought about Halifax and its past.

In a little while some scattered explosions could be heard, then more smoke started up. Flashes of fire could be seen from where we were, and soon our public address system announced that Halifax, once more, was the epicentre of blast from an exploding ammunition dump!

Poor Halifax! How many times she has had her face shattered by explosions from one cause or another. There was that dreadful holocaust in 1917 in which a couple of thousand lost their lives. In 1941, too, a ship was blown up in the harbour, without damage it is true, but with a shock to those who remembered the last debacle. And then, the downtown section was wrecked and devas-

tated during the V-E Day riots in May, 1945! The awful part of that day's events was the realization that, while the greater part of humanity was celebrating the end of ruin and destruction in Europe, a mob in Halifax was creating ruin and destruction there!

When I arrived in Halifax on July 12, 1945, its streets were still pock-marked from those riots. Some of the windows in the shopping district were still boarded up, and, though the promise of new store-fronts pleased many of the natives, the merchants who had to bear the expense of repairs were still trying to procure plate glass and workmen to instal it. And - today all is chaos again! As I walked through the streets the whole town looked pathetic and dispirited. Windows newly put in were just shattered heaps on the sidewalks: upper floors of buildings had large gaping holes where there had been windows; and St. Matthew's Church, where we had attended service just a few days before, had a large arched hole where a stained glass window had adorned the tower over lovely oak doors. Demolition and destruction were everywhere, while at street corners serious people gathered in clusters to relate their reactions to the past frightening and sleepless night, and to speculate with apprehension on the immediate future, which was enough to terrify anyone.

All night long, the intermittent explosions punctuated the normal noises of city life, and all night long, flashes of light and shooting particles lit up the blackness. Eerily, the outlines of buildings were silhouetted against the flares at irregular intervals, and fearfully we awaited news of how much destruction was being wrought.

You see, we were on duty on the hospital ship, Letitia, which was tied up in the harbour after returning from Europe with war casualties a few days before. The whole staff was ordered to "stand by" for eventualities, and we hastily made up beds and opened wards for the receipt of possible patients from the danger area. Most of the night we paced up and down the ship's passageways fearful of every succeeding blast. The two four o'clock blasts made the ship



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rock and shudder, and we wondered if the main "dump" was in any danger of exploding.

By breakfast time we were still fearful and anxious because, according to the newspapers, the danger was not yet passed, although the explosions had diminished since the early morning blasts — but the largest ammunition dumps were in the path of the heat and flame of the extending fire! The fear was expressed that, if the main dumps went off, the whole town would be decimated!

In the meantime, Halifax Military Hospital, quite close to the danger area, had evacuated most of its patients to make room for more that might come. We had taken fifty-eight of these patients on board and were keeping them until the danger was passed; some were victims of the blast but none seriously hurt. To everyone's unbounded relief the danger was declared to be over about mid-afternoon and the city learned with thankfulness that the main dumps had been successfully flooded.

Those unfortunates, who had been evacuated from the immediate vicinity and who had spent twenty-four hours in open parks and, public buildings at a safe distance. started their trek back to their homes. They were all tired, especially the older ones, but they were all good-natured, and many a sally was heard amongst different groups as each tried to bolster up the courage of the other. Volunteer groups appeared from nowhere and ministered to the hundreds. Coffee and sandwiches arrived from all directions and neighbouring communities wired to see what they could do to help. It takes a disaster to show up the best in people. However, all is now quiet again — the city has returned to its normal routine. Stores are open for business, even though their fronts are just gaping holes again. Deliveries are being made and an unmistakable air of relief is abroad as people start to count the cost and prepare for whatever the future holds. The air is clear of smoke, the sky is very blue and it even has some white puffy clouds floating around. The sea is again tossing around its colours as we prepare our hospital ship for another voyage for more Canadian war casualties.

-NURSING SISTER B. JENKINS.

Victorian Order of Nurses for Canada

Victorian Order scholarships for the purpose of assisting nurses to take post-graduate study in public health nursing have been awarded to the following nurses who are attending the universities indicated:

University of Alberta: Eleanor Jamieson Hilda Law, Ruth Sheppard.

University of British Columbia: Margaret Forry.

University of Manitoba: Irene Halford, Mrs. Jean Howey, Merle Pringle.

McGill University: Ruth Franklin, Margaret Joyce, Margaret Lownds, Christene MacKaracher, Patricia Merriman, Mrs. Bettie Norris, Mrs. Marjorie Salter, Marion Shore, Evelyn Weaver.

University of Toronto: Phyllis Beardsall, Evelyn Boyd, Mary Clancy, Violet Dick, Marian Doherty, Bernice Giles, Helen Gowdy, Frances Hewgill, Ethel Irwin, Ruth Kirkpatrick, Janet Laing, Olwin McInnes, Marjorie McIntosh, Elizabeth McKenna, Edith McKerlie, Violet Mabee, Velma Martin, Adella Matusaitis, Edith Rose, Eva Secord, Hilda Tackaberry, Edna-Valiquette, Lorna Warman, Mrs. Gwen Watt, Mary Whiteside.

University of Western Ontario: Betty Brown, Claire Hicks, Doris Kirkwood, Mary Leyden, Barbara Shook, Helen Thompson, Annie Wade, Elsie White.

The following nurses have been appointed to the Toronto staff:

Doris M. Campbell has returned to the staff on the completion of her post-graduate studies in public health nursing at the University of Toronto; Margaret Anderson (Wellesley Hospital, Toronto); Mary Comartin (St. Michael's Hospital); Iva D. Curry (St. Joseph's Hospital, Toronto); Lois Gorman (Hospital for Sick Children, Toronto); Margaret Janzen (Women's College Hospital, Toronto); Elizabeth Kerswill (Toronto General Hospital); Ruth



Watson (Women's College Hospital, Toronto); Madeline Weber (Toronto Western Hospital); Phyllis M. Keep (Grey Nuns' Hospital, Regina); Mary I. Morrell (Toronto General Hospital); Grace Pilger (Women's College Hospital, Toronto); Florence Sinclair (Toronto Western Hospital). These nurses are all graduates of the certificate course in public heatlh nursing at the University of Toronto.

The following nurses have been appointed to the Montreal staff:

Laure Bergeron (Ottawa General Hospital); Reta Coady (Charlottetown Hospital); Beryle Hawley has been re-appointed to the staff on the completion of her post-graduate studies in public health nursing. These nurses are graduates of the certificate course in public health nursing at McGill University.

The following nurses have been appointed to the Vancouver staff:

Mrs. Ennis Hayward (Vancouver General Hospital; B.A.Sc., University of B.C.); Mrs. Kathleen Hyslop (Vancouver General Hospital) and Liana Marano (Edmonton General Hospital), both graduates of

the certificate course in public health nursing, University of B.C.

Margaret A. Campbell (St. Joseph's Hospital, Victoria, and course in public health nursing, University of B.C.) and Verna Campbell (Brantford General Hospital and course in public health nursing, University of Toronto) have been appointed to the York Township staff.

M. Hope Gauld (University Hospital, Edmonton; B.Sc., University of Alberta) has been appointed to the Victoria staff.

Julia Meyer, having completed the course in public health nursing at the University of Western Ontario, has returned to the Order and has been appointed nurse-in-charge of the Whitby Branch.

Margaret McNabb (Victoria Hospital, London; B.Sc.N., University of Western Ontario) has returned to the Order and has been appointed to the Hamilton staff.

Mabel Russell (Homoeopathic Hospital, Montreal, and course in public health aursing, McGill University) has been appointed to the North Vancouver staff.

Carol E. Sellhorn (University Hospital,

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Edmonton; B.Sc., University of Alberta) has been appointed to the Edmonton staff.

Marion Schwanbeck (St. Michael's Hospital, Toronto, and course in public health nursing, University of Toronto) has been appointed to the Saskatoon staff.

Helen Voss, having completed the course in public health nursing, University of B.C., has returned to the Order and has been appointed to the Sarnia staff.

Marion Werry (Brantfdro General Hospital and course in public health nursing, University of Toronto) has been appointed to the Belleville staff.

G. Vivian Adair has been transferred from the Ottawa staff to take charge of the Belleville Branch. Olive Bell has been transferred from the Sydney staff to take charge of the Brockville Branch. Grace Versey has been transferred from the Toronto staff to take charge of the London Branch. Ethel Gordon has been transferred from the Belleville Branch to the position of assistant superintendent of the Ottawa Branch. Lucille Beaudet has been transferred from the Digby to the Sherbrooke staff. Mrs. Catherine

Kelly has been transferred from the London to the Vancouver staff. Therese Laframboise has been transferred from the Border Cities to the Montreal staff. Marion Wismer has been transferred from the Montreal to the Vancouver staff. Margaret Allen has been transferred from the Dartmouth to the Saint John staff.

Mrs. Margaret Houlgrave, Ruth Abell, Mrs. Frances Dalziel and Agnes Collver have resigned from the Toronto staff, the latter having accepted a position with the Toronto Department of Health. Ada Benvie has resigned as nurse-in-charge of the Wolfville Branch and is retiring from active nursing. Dorothy Crozier has resigned as nurse-in-charge of the St. Thomas Branch to take up other work. Mary Mercer and Mrs. Kay Jenkins have resigned from the Montreal staff. Lillian Fryers has resigned from the Winnipeg staff to take up other work. Lora Furhop has resigned from the Surrey staff to accept a position with the Provincial Department of Health, Alberta. Geraldine Garnett has resigned as nurse-incharge of the Brockville Branch to be mar-

ried. Susie Jones has resigned from the Victoria staff and has accepted a position with the Provincial Department of Health, B.C. Elizabeth Patterson has resigned as nursein-charge of the Whitby Branch and is retiring from active nursing. Verona Smith has resigned from the Victoria staff and has accepted a position as health teacher in St. Joseph's Hospital Training School, Toronto. Anna Whiston has resigned as nursein-charge of the Bridgewater Branch.

New Brunswick

Public Health Nursing Service

Ray McKenzie (Montreal General Hospital and McGill University public health course) has been appointed to Carleton county.

Corinne Pichette (St. François d'Assise Hospital, Quebec City, and University of Montreal public health course) has been appointed to Madawaska County.

Dorothy Titus (Saint John General Hospital and McGill University public health course) has been appointed to York County replacing Cecilia Pope who has resigned.

Katherine MacLaggan (Royal Victoria Hospital and McGill University public health course) has been appointed to organize the work in Westmorland County.

Ontario

Public Health Nursing Service

Marjorie Rutherford (Victoria Hospital, London, and University of Western Ontario public health course) recently returned from overseas service with the R.C.A.M.C., and has accepted the appointment of public health nursing supervisor of the Elgin-St. Thomas Health Unit.

Marion Thompson (Toronto General Hospital and University of Toronto certificate course in public health nursing and lecture course in administration and supervision)



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For further information apply to:

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Miss F. Munroe, R. N., Superintendent of Nurses, Royal Victoria Hospital, Montreal, P. O.

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and Elizabeth Gillespie (Hospital for Sick Children, Toronto, and University of Toronto public health course, and McGill University course in supervision in public health nursing) have been appointed supervisors with the Windsor Department of Health which has recently taken over the School Nursing Service and organized a generalized program.

Mrs. Dorothy (Armstrong) Shapter (Hamilton General Hospital and University of Western Ontario public health course) has accepted an appointment on the staff of the Elgin-St. Thomas Health Unit.

Kathlyn B. MacDonell (University of Ottawa School of Nursing and McGill University public health course) has accepted a position with the York Township Board of Health.

Ann Sumka (St. Boniface Hospital and McGill University public health course) has accepted an appointment with the East York Dept. of Health.

Goldie Duncanson (St. Joseph's Hospital, London, and University of Western Ontario public health course) has accepted an appointment with the Chatham Board of Health.

Alli Huhta (St. Mary's Hospital, Timmins, and University of Toronto public health course), Olive Smith (Toronto General Hospital and University of Toronto public health course), and Ina Vokes (St. Joseph's Hospital, Hamilton, and University of Western Ontario public health course) have accepted appointments with the St. Catharines-Lincoln Health Unit.

Elizabeth Ryan (St. Joseph's Hospital, London, and University of Western Ontario public health course) has accepted an appointment with the Sarnia Board of Health.

Florence Stewart (Toronto General Hospital and University of Toronto public health course) has accepted an appointment with the Guelph Board of Health.

M.L.I.C. Nursing Service

Rita Chamberland (St. Sacrement Hospital, Quebec City), Mariette Leger (Notre Dame Hospital, Montreal), and Lucinda Le-

may (Notre Dame Hospital, Montreal, and University of Montreal public health course) have been appointed to the Metropolitan nursing staff, Montreal.

Madelcine Bulteau (Ste. Jeanne d'Arc Hospital, Montreal, and University of Montreal public health nursing course) was transferred recently from Montreal to take charge of the Service in Joliette. Alma Morache (Notre Dame Hospital, Montreal and public health course, McGill School for Graduate Nurses), who has been in charge of the Service in Niagara Falls, was transferred recently to Montreal.

Jeanne d'Arc Hamel (St. Sacrement Hospital, Quebec City) has been granted a Company scholarship, and leave of absence from the Quebec City nursing staff, to take the public health course at the University of Montreal. Simonne Rouillard (St. Luc Hospital, Montreal, and University of Montreal public health course) will take leave of absence from the Montreal staff to take up further nursing studies at McGill University with a Company scholarship.

Jeannette Coulombe (St. Sacrement Hospital, Quebec City), who was on the Quebec city nursing staff, recently resigned from the Company's service. Ina Dickie (Hamilton General Hospital and University of Western Ontario public health course), who was in charge of the nursing service in Sudbury, has resigned to take up further nursing studies.

NEWS NOTES

ALBERTA

EDMONTON:

The Royal Alexandra Hospital Alumnae Association recently held its opening meeting of the season, with the president, V. Chapman, in the chair. Plans were completed for a bazaar to be held in November, the proceeds to go towards the scholarship and sick benefit funds. The meeting took the form of a shower of articles for the bazaar and many beautiful gifts were received. This year the annual scholarship has been awarded to Jean MacKie of the Class of 1943 who is taking a post-graduate course in administration at the University of Toronto School of Nursing.

The first regular meeting of the University of Alberta Hospital Alumnae Association was held recently when plans for the future were discussed. These include a dance, an open forum under the direction of the public health section, a student nurses' night,



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a supper meeting, and a night when scientific medical films will be shown in co-operation with the Association of Scientific Workers.

Four new committees have been set up as follows: (1) A public health section under Helen McArthur; (2) a hospital and general nursing section under Peggy Wylde; (3) liaison with the Alberta Association of Registered Nurses, D. Guild, P. Holowaychuk, Mrs. J. Sleath; (4) a committee to study legislation in Canada and Alberta which affects the status and working conditions of nurses under Mmes W. Hahn and R. Milner.

Elizabeth Rogers addressed the members on the work of the A.A.R.N. of which she is executive secretary. Following other provinces, Alberta is to set up a Nurse Placement Bureau. Miss Rogers explained the salary schedule that the association has drawn up and is at present negotiating with representatives of the Alberta Hospital Association.

The alumnae executive for the 1945-46 term follows: president, Mrs. J. Morrison; vice-president, Mrs. R. Sellhorn; recording secretary, B. Armitage; corresponding secretary, R. Fadum; treasurer, V. Clark; social committee, E. Markstead, E. Eckmeyer.

BRITISH COLUMBIA

COWICHAN DISTRICT:

The annual meeting of the Chapter of the R.N.A. of Cowichan District was held during the summer at King's Daughters Hospital, Duncan, when the following officers were elected: president, Mrs. H. Russell; vice-president, Mrs. T. Skillicorn; secretary-treasurer, K. M. Struthers; social convener, M. Wolfe; press representative, I. Howard.

It was suggested that, for the coming year, every second meeting be devoted to discussions on nursing problems, the alternate meetings to be of a social nature to which all graduate nurses in the District be invited.

ONTARIO

Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Gena Bamforth, 54 The Oaks, Bain Ave., Toronto 6.

DISTRICT 4

ST. CATHARINES:

A well attended regular meeting of the Niagara Peninsula Chapter, District 4,

R.N.A.O., was held recently at the Leonard Nurses Home. The chairman, Stella Murray, welcomed those present and minutes of the last meeting were read by Mrs. J. D. Lynn, secretary-treasurer. Interesting reports were heard as follows: Investigation on Job Instruction Methods, by Helen Brown; Hospital Schools of Nursing, by Norma Newman; General Nursing Section, by Catharine O'Farrell.

Lieut. Eleanor Rider, nursing sister attached to the American Army and a St. Catharines General Hospital graduate, was welcomed at this meeting. The association was also pleased to have with them Jean Scrimgeour who, until recently, was a nursing sister with the R.C.A.M.C. N/S Scrimgeour was one of the survivors who did such a gallant piece of rescue work when the ill-fated Santa Helena was torpedoed and sunk in the Mediterranean in November, 1943. Public health nurses from the Lincoln County Health Unit and the Welland-Crowland Health Unit were also welcomed.

Through the courtesy of the Lincoln County Medical Association the members heard an informative address on Penicillin and Streptomycin which was given by Dr. Philip Greey of the Banting Institute.

WELLAND:

The opening gathering of the Welland Nurses Association took the form of an enjoyable weiner and corn roast at the home of Mrs. J. Reuter. A short business meeting was held and \$100 was donated for purchasing heavy coats and capes for nurses in the Netherlands.

At the October meeting Mrs. C. Hill, the president, was in charge. Plans were made to hold a card party. Ten dollars was don-ated to the Salvation Army and a contribution was made to the Welland Children's Aid Society. Anne Jack, who recently became associated with the Welland-Crowland Health Unit, told of her experiences with No. 15 Canadian General Hospital in Africa. Mrs. E. Hanna thanked the speaker. A social hour followed.

OUEBEC

MONTREAL:

Royal Victoria Hospital:

E. Mansfield is in charge of the private ward of the newly opened military annex of the Montreal Neurological Institute. V. Young is in charge of the public ward. H. Lamont is now in the training school office as supervisor of the medical wards. L. Ellis has charge of the urological department. Major Christine Crawford, R.R.C., is now matron of the hospital ship Letitia en route to Hong Kong. Mrs. M. (Stacey) McQueen





By D. M. Baltzan

Just off the press. A course for nurses. Dr. Baltzan has taught this course for a number of years with great success. The book is an amplification of his lectures. Chapters are: I. Discase: II. Disorders of Respiration; III. Disorders of the Circulatory System; IV. Disorders of the Blood; V. Renal Disorders; VI. Disorders of the Digestive System; VII. Disorders of the Endocrine Glands; VIII. Neuropathological Disorders; IX. Psychopathological Disorders; X. Disorders of the Skeletal System.

Dr. Baltzan is chief of medicine, St. Paul's Hospital, Saskatoon, Saskatchewan, and Senior Lecturer in Medicine, Nurses Train-ing Schools, St. Paul's and City Hospital, affiliated with the University of Saskat-chewan, 398 pages, \$5.00.

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REGISTRATION OF NURSES
Province of Ontario

EXAMINATION ANNOUNCEMENT

An examination for the Registration of Nurses in the Province of Ontario will be held on November 21, 22, and 23.

Application forms, information regarding subjects of examination and general information relating thereto, may be had upon written application to:

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recently resigned her position as assistant head nurse of the 1st floor east, Allan Mem-

The following nurses have registered at the McGill School for Graduate Nurses: Julia Cookson, Florence Gass, Edith Green, teaching and supervision certificate course; Violet Boone and the recently discharged nursing sisters D. Carter, G. Hopkins, I. MacKay, E. Rowell, public health certificate course; N/S Sheila Mingie, public health degree course; Jean McGregor, Jean Thirlaway, teaching and supervision degree course. N/S Wilhelmina Bell and Frances Simpson are taking the teaching and supervision course at the University of Toronto School of Nursing.

Mrs. C. (King) Bell was a recent visitor at the hospital. Mrs. A. (Pickard) Crawford has returned with her family to Beirut, Syria, after spending several war years at her former home in Sackville, N.B.

SASKATCHEWAN

MOOSE JAW:

Naomi Webber (Regina General Hospital and University of Saskatchewan School of Nursing) has been appointed instructress at the Providence Hospital. Florence Kuntz is leaving the staff of this hospital shortly for the east.

PRINCE ALBERT:

Rev. Sr. Symphorosa, directress of the Holy Family Nursing School for the past eighteen years, has been transferred to Vancouver. An entertainment was held in her honour prior to her departure. Rev. Sr. Irene and Sr. Agnes Patricia have returned from Eastern Canada where they attended summer school and classes at Loyola College, Montreal. N/S Ruth (Nordstrom) Blight has recently returned from overseas.

The Victoria Hospital Nursing School recently held their graduation exercises in the United Church.

REGINA:

F. Philo has been appointed instructress of nurses and Noreen Mullen is teaching practical nursing at the Grey Nuns' Hospital. A class of fifty-three students has just been enrolled, Mrs. Ann Hernoi, Mrs. E. L. Lach and Miss Bolstad have been appointed to the maternity department. Mary Karabis has accepted a position at St. Peter's Hospital, Melville. Mrs. A. Dwight has resigned to make her home in B. C.

YORKTON:

Alice Mills, recently on the staff of the Yorkton General Hospital, has accepted a position at the hospital in Dawson City, Yukon. N/S Betty Langstaff has returned to Canada after spending four years with the South African Nursing Service. N/S Langstaff has served in South Africa, Egypt and Italy.



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Both positions available immediately. Cost of railway ticket to Edmonton will be refunded after six months service. Apply, stating qualifications and experience, to:

Superintendent of Nurses, University Hospital, Edmonton, Alta.

WANTED

A competent nurse is required for the position of Operating Room Supervisor. Apply, with references, stating experience and salary required to:

Superintendent, Prince County Hospital, Summerside, P. E. I.

WANTED

Registered Nurses are required for the Huntingdon County Hospital. The salary is \$80 per month with room and board provided. For further particulars apply to:

Dr. H. R. Clouston, Superintendent, Huntingdon County Hospital, Huntingdon, P. Q.

WANTED

General Duty Nurses are required for a 350-bed Tuberculosis Hospital. Forty-eight and a half hour week, with one full day off. The salary is \$100. per month, with full maintenance. Excellent living conditions. Experience unnecessary. Apply, stating age, etc., to:

Miss M. L. Buchanan, Supt. of Nurses, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P. Q.

WANTED

A class room Instructress for a 120-bed hospital. Apply stating qualifications, experience and salary expected to:

The Superintendent, Stratford General Hospital, Stratford, Ont.

WANTED

Applications are invited for the position of permanent Night Supervisor at a salary of \$95 per month. Floor duty nurses are also required at a salary of \$85 per month. Apply to:

Superintendent, Barrie Memorial Hospital, Ormstown, P. Q.

WANTED

Vancouver General Hospital desires applications from Registered Nurses for General Duty. State in first letter date of graduation, experience, references, etc., and when services would be available.

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Miss E. M. Palliser, Director of Nurses, Vancouver General Hospital Vancouver, B. C.

WANTED

A Dietitian and a Supervisor for a Tuberculosis Annex are required immediately for the Highland View Hospital, Amherst. Apply, stating qualifications, to:

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Superintendent, Grace Hospital, Ottawa, Ont.

Official Directory

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DECEMBER 1 9 4 5

THE CANADIAN NURSE



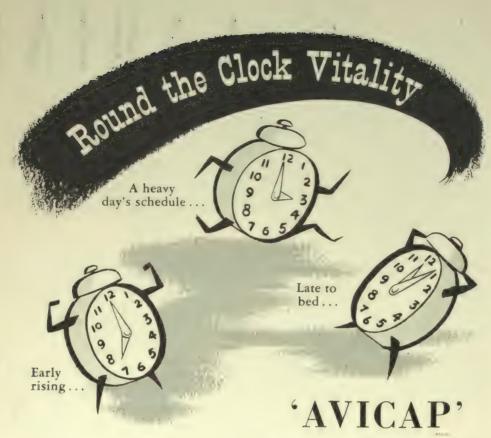
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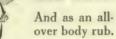
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917

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COURAGE, boundless optimism and breadth of vision characterized the distinguished career of Sir Charles Tupper. Despite the demands of public office, he maintained an active interest in all matters concerning the medical profession.

Tupper was born at Amherst, N.S., July 2nd, 1821. He studied medicine at Edinburgh University where he received the degrees of M.D. and L.R.C.S. in 1843. Of medium height, erect, and vigorous, Charles Tupper had an abundance of nervous energy which contributed to alertness and ceaseless mental activity. His manner was hearty and genial and he had a broad grasp of most topics.

In 1862 Tupper was appointed a Governor of Dalhousie College, Halifax, where he initiated a medical course which reached full fruition in 1870. It was largely due to his persistence that in 1867 the Victoria General Hospital began its existence in Halifax as a provincial and city institution. When the Canadian Medical Association was formed in 1867 he was elected President.

The year 1855 marked the beginning of Tupper's political career. It is said that history will record the four years of his administration as Premier of the Province of Nova Scotia as the greatest era in Tupper's life—an era in which he achieved the most striking personal success. Against strong opposition he established a system of free schools for Nova Scotia.

Tupper was the apostle of Confederation and played an important part in the passage of the British North America Act. He actively supported efforts to establish a Federal Department of Health which, after much missionary work, became a reality in 1919.

He was made a Baronet in 1888. For two different periods he held the position of High Commissioner for the Dominion in London and in 1896, was made Prime Minister of Canada.

Sir Charles died at "The Mount", Bexley Heath, England, on October 30th, 1915. The record of his life is a challenge to the medical profession and inspires William R. Warner & Company in their policy of Therapeutic Exact-

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Reader's Guide

The arguments for early immunization against whooping-cough, presented so ably by Dr. Lawrence E. Ranta, will serve to reinforce the programs conducted by public health nurses everywhere. The high percentage of the deaths from this disease which occur among infants under one year can be markedly reduced if adequate protection is secured at an early age. The case which he presents for scarlet fever immunization should help to combat the widespread reluctance to accept this means of ensuring even the more limited security which is afforded. Dr. Ranta is assistant director of the Connaught Laboratories (Western Division) and assistant professor in the Department of Bacteriology and Preventive Medicine at the University of British Columbia.

Dr. S. A. MacDonald, of Montreal, has given us an interesting description of the various types of paralyzed bladder and a detailed account of one particular patient. Using this same case as an excellent example, Clara R. Aitkenhead, chief instructress at the Homoeopathic Hospital, Montreal, has shown how teaching opportunities may be turned to good account.

Under the auspices of the Alberta Association of Registered Nurses and the School of Nursing of the University of Alberta, a course in hospital administration was provided. W. J. Coleman, a representative of a hospital supply company, presented the exceedingly valuable suggestions for the preservation of hospital equipment to this group. The many useful points which he has included will, we hope, help the harassed hospital personnel to make this last until new materials are again available.

In the November issue of the *Journal* we presented the first instalment of Edith Buchanan's interesting and timely

story of nursing conditions in India. This month we conclude her account of the efforts that are being made to raise the standard of training being provided and to make a greater volume of nursing care available to India's teeming millions. Miss Buchanan is a graduate of the Royal Victoria Hospital, Montreal.

Dorothy L. Ward is a graduate of the Homoeopathic Hospital, Montreal. At present, she is taking her course in teaching and supervision at the McGill School for Graduate Nurses, preparatory to returning to her alma mater as a chinical instructor.

Margaret O. Cogswell, recently appointed as director of the newly organized Nurse Placement Bureau in Alberta, sets a pattern, which Instructors' Groups in every community might well copy, in her description of the monthly gatherings held in Edmonton. Similarly, Hester Lusted shows a way in which public health nurses may expand their knowledge and understanding of the community in which they work and its possible resources. Miss Lusted is a public health nurse in Regina, Sask. The thoughtful presentation of the possibilities to be found in a small community hospital by Jean White should be an eye-opener to many nurses who have never lived anywhere but in the city and whose professional experience has all been in large hospitals.

The four small tots depicted on our cover did not wait in vain for a visit from good St. Nicholas. The empty fire-place permitted the jovial gentleman to arrive without even scorching his whiskers. It is our sincere wish that this Christmas will bring the heart's desire to all of our readers, with a full measure of happiness to carry over into the New Year. Merry Christmas!



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* (olebrook, L. (1933) J. Obstet. & Gynaec., 40, 977.

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"WHY 'DETTOL' OBSTETRIC CREAM?"

IN ALL ESSENTIALS 'Dettol' Obstetric Cream has the same properties as the modern antiseptic, 'Dettol' liquid—no more, no less. Like the liquid, it is rapidly lethal to a diversity of pathogenic organisms, including the hæmolytic streptococci responsible for most cases of puerperal infection: again like the liquid, it is a non-toxic, non-irritant preparation which can be applied repeatedly without danger or discomfort: and both preparations are pleasant in use.

Nevertheless, 'Dettol' Obstetric Cream has its special place in obstetric practice. Firstly, the antiseptic in this form is ready to use at the right concentration—namely 30% 'Dettol'—in a suitable vehicle: secondly, unlike liquid preparations, when applied to the patient's skin and mucous membranes, it remains

confined to the site of application: and thirdly, 'Dettol' Obstetric Cream 'stays put' and so forms a barrier to reinfection effective for over two hours.

Thus, 'Dettol' Obstetric Cream is 'Dettol' in a form particularly suitable for the disinfection of the doctor's and nurse's gloved hands as well as of the patient's vulva, thighs and hands. It is not more effective than 'Dettol' liquid at 'the same strength—but for these particular purposes it is more convenient.

At London's great maternity hospital, Queen Charlotte's, records show that in the two-and-a-half years following the introduction of an antiseptic technique involving the use of 'Dettol' liquid and 'Dettol' Obstetric Cream, the incidence of puerperal infection due to haemolytic streptococci was reduced by more than 50% when compared with a similar period immediately prior to the use of these products.

RECKITT & COLMAN (CANADA) LIMITED, PHARMACEUTICAL DIVISION, MONTREAL, Cr.2c.

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Pulling the Drawstrings

Every good knitter has a bag into which she puts the odds and ends of yarn she has left over. Sometimes it will be a fair-sized ball, sometimes only a short strand. Periodically, she has a house-cleaning of this bag of left-overs and knits up the wool into more useful articles — coat-hanger covers, tea-cosies, afghan squares, babies' bootees, even darning holes in sweaters or socks — none of it is wasted. When the oddments are all sorted out, the bag is put away to become a store-room for further treasures.

Coming to the end of this year 1945, let us go through our work-bag. There are many colours left there from which we may make a pattern. Lord Byron once said, "The best prophet of the future is the past". What colours have we from which to weave our future?

First, there are the long, bright strands labelled V-E Day and V-J Day. What gloriously warm, rich hues those days were! The war was over in Europe and,

in an amazingly short time thereafter, the war in the far eastern theatre came to an end. Golden threads a-plenty, as from far and near absent relatives and friends flocked homeward. There are sombre colours here, too, which reach across to grave-markers in many foreign lands. Some of the shades are dull just now, which next year may be brighter as the sick, the wounded, the prisoners-of-war are restored to the fullest possible measure of health. Bright threads, glad threads of victory!

Many more shining colours are over in this corner of our bag. These are all the hundreds of new friends the Journal has made in the past year. Every section of the Dominion has contributed strands to this ball. Student nurses, graduates, retired nurses, married nurses — a mighty assembly of friends to whom The Canadian Nurse is a welcome helper each month. The kindness and forebearance when delivery has been late has added an especial gleam to

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these colours. These new colours blend well with the larger pattern of our thousands of old tried and true friends. May there be a host of new strands added to our work-basket next year!

A very large measure of the success of this past twelve months has been due to the multi-coloured mosaic woven by our contributors. Already, a very interesting pattern is taking shape for the months to come. In one section of the total colour scheme, the material has been a bit skimpy recently, leaving some unwanted gaps. "News Notes", which tells the more intimate story of nursing activity all over Canada, has not had threads from many of the provinces. Perhaps when the 1946 package un-

folds, these pieces will be found more plentifully scattered.

There are so many other colours in our work-bag—the vibrant hues of music, the comfortable friendliness of books—shades and tints to numerous to mention. Christmas itself with its festive reds and greens is upon us. Let us pull the draw-strings on 1945 and wish to all those who have blended their colours with ours a very happy Christmas, quite the gayest and most joyful in many a year. For the New Year, the editor and staff of the Journal wish all of our readers success, great happiness, and a renewal of your subscription!

-M.E.K.

Competition Winners

We have much pleasure in announcing the names of the winners in the recent competition sponsored by The Canadian Nurse. The four winning papers will be published next year starting with the February issue. To each of these winners we offer our hearty congratulations and to all the contestants our appreciation of your response. It is hoped that a larger number will watch

for the next competition, the topic for which will be announced early in the New Year.

The winning entries were written by: First place, Miss Grace Giles, Saskatoon, Sask.; second place, Miss Helen Saunders, Victoria, B.C.; third place, Mrs. Eileen Mayo, Toronto, Ont.; honourable mention, Miss Elizabeth Tweedie, Westmount, P.Q.

Preview

While there have been periodic articles dealing with various aspects of tuberculosis affiliation, etc., in recent issues, next month we propose to devote a considerable part of the *Journal* to this topic. Heading the list will be a very excellent and informative discussion on operative treatment of the disease through thoracoplasty. Dr. G. H. Hames describes the procedure in detail. Preoperative and post-operative nursing

care will be outlined by Elsie Towers and Helene Kirkpatrick. What it feels like to be the patient is humorously portrayed by B. M. Evjen. A description of fluorographic surveys and the programs for the prevention of tuberculosis in Saskatchewan comes from the able pen of Grace Giles. Finally, a discussion on the scope and challenge of tuberculosis nursing written by Esther Paulson will round out this interesting and vital series.

Too Late and Too Little

LAWRENCE E. RANTA, M.D., D.P.H.

Usually with mixed feelings of pity and impatience, most members of nursing and kindred professions eventually cross words with conscientious objectors who voice disapproval of vaccination, chlorination, pasteurization, some equally well-established health measure; and in the process of crystallizing a public health practice we often joust among ourselves. But our criticisms should not be the thrusts of a superior attitude, lest we, in turn, go misunderstood when we couch a lance from the back of our favourite "hobby-horse": for none of us ever escape completely from preconceptions and prejudices. However, if we hope to fly the banner of the "Modern Crusade" and realize our ambitions as health teachers in the community, we must ever make efforts to clarify our ideas regarding the best procedures in all branches of health preservation.

PERTUSSIS IMMUNIZATION

Disappointment in the older type of pertussis vaccine, made from an avirulent strain of *H. pertussis*, might be adequate reason to excuse us should we look skeptically upon later modifications. But we cannot spurn the proof offered by many excellent workers in Canada, United States, and elsewhere, that whooping cough can be prevented by inoculations with a vaccine prepared from Phase I, *H. pertussis*.

During the pioneer work with this newer vaccine attention was paid primarily to prevention of morbidity. The selection of older infants for immunization, though really governed by experimental necessity, has probably been responsible for the reluctance of many practitioners to administer pertussis vac-

cine until the infant approaches the first birthday. But, as Phase I pertussis vaccine has demonstrated its ability to prevent morbidity, we must consider how it can be used in the best interests of public health.

Each year of the first decade of life contributes about 10 per cent of the total cases of whooping cough, hence, inoculations of vaccine commenced towards the end of the first year of age could, ideally, influence 90 per cent of the prospective cases. But, although children under one year suffer only 10 per cent of cases, they contribute about 75 per cent of the total whooping cough fatalities. For example, in a typical year (1942), of 560 Canadians dying of whooping cough, 413 (73.7 per cent of the total) were less than a year old, and 499 (89.1 per cent) were under two years of age. In Chart I, the curve represents the percentage of the total number of fatalities from whooping cough occurring up to the age at which the curve cuts a vertical line. The steep upward sweep of the curve during the first year reveals how every month of infancy is paid for by a heavy toll of victims caused by our delay in stimulating resistance against H. pertussis. The obvious flattening of the curve after the second birthday indicates a marked lowering of the case fatality rate in the older age-groups. It is clear that, if establishment of immunity is delayed until the end of the first year in accord with widely prevalent practices, the best result we can hope for is a reduction of whooping cough mortality by approximately 25 per cent. This would still leave whooping cough at the top of the list of infanticidal communicable diseases. Consequently, our objective must be a postponement of the disease to any time after the second birthday. Moreover, the ar-

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gument for early immunization is strengthened by the contention that pertussis immunity does not become solidly established until the third or fourth month after completion of the vaccine series.

Therefore, giving consideration to the innocuous nature of the immunizing agent, to the high case fatality rate during infancy, and to the delay in acquiring immunity after vaccination, pertussis immunization should be commenced as early as the second month after birth. The practicability of early immunization should be judged by the attending physician upon the infant's physical condition and development. If these are normal, or if the risk of exposure is great, there is no reason to postpone inoculation; for the argument that a young infant fails to develop immune bodies against H. Pertussis is not supported in the literature. But as the response to vaccination may not be as durable as that of an older infant, a reinforcing dose should be given on the first birthday.

It should be emphasized that pertussis immunization begun during the second month will not solve the problem of whooping cough fatalities: reference to Chart I will obviate further elaboration. But even though earlier immunization cannot recall the victims of our ignorance of better preventive practices, it can reduce the number of victims of our procrastination in the use of the tools at hand, until future developments either confirm the possibility of immunizing prospective mothers against whooping cough during the middle trimester of pregnancy, or provide us with more effective, rapidly acting, prophylactic measures.

The establishment of pertussis immunity may be secured by inoculations of pertussis vaccine alone, or in combination with diphtheria toxoid. The latter preparation has the real advantage of reducing the total number of immunizing injections.

The theoretical objection, that the ability of diphtheria toxoid to elicit antibodies may be neutralized by the passive-

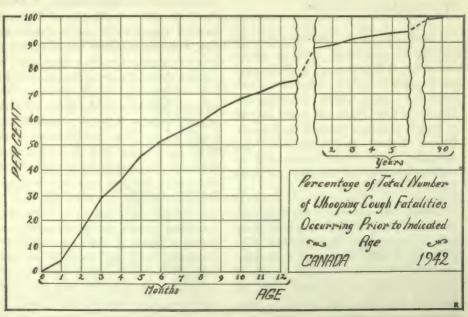


Chart I

ly transferred maternal antibodies possessed by many newly born, has not been proven by trial; on the contrary, there is much to nullify the objection. For some years after active immunization with diphtheria toxoid an individual possesses antibodies sufficient to confer immunity against the average infecting dose of C. diphtheriae, and to produce a negative Schick reaction. Yet even in these individuals a dose of diphtheria toxoid will, within certain reasonable limits, elevate their antibody titre to a higher level. In other words, despite the existence of circulating antibodies in appreciable quantities, the toxoid reinforces the antibody level.

One may also argue in favour of the combined immunizing agent by pointing out that many large-scale Schick-testing surveys of persons in the reproductive age showed that more than half often possessed insufficient antibodies to render them Schick-negative. Therefore, many thousands of Canadian infants are born without passive protection against diphtheria, and would profit from the diphtheria toxoid in the combined preparation.

SCARLET FEVER IMMUNIZATION

We do not condemn the use of pertussis vaccine on the grounds that it fails to justify itself as a "cure-all" of the whooping cough problem. Similarly, we should not label scarlet fever immunization as a useless procedure simply because it is unable to do all that we desire of it. But, oddly enough, some laboratory and public health workers thrill with an impulse to do battle when it is suggested that immunization against scarlet fever may have merits. However, scarlet fever immunization has many supporters among equally well-qualified and conscientious workers, and this support would imply that something can be said in its favour.

The objectors base their opposition on the claim that scarlet fever immunization prevents only the appearance of the rash when an individual becomes infected by an erythrotoxigenic strain of streptococcus and, as public health regulations do not ordinarily call for isolation of the rashless streptococcally infected, this procedure actually encourages the spread of streptococci. If erythrogenic toxin had a selective action solely upon the skin, the objectors could voice their opinions as though from an impregnable tower, conscious of their ability to withstand siege. But, can the mere act of naming a toxin limit its toxicity to the terms of its descriptive adjective? A misconception of this type has been responsible for placing too much emphasis upon the erythema-producing quality of erythrogenic toxin. The tendency has been to lose sight of the fact that the toxin does not act on the skin per se. The rash has wider significance. It indicates that toxin has been elaborated at the site of infection, usually in the throat, that it has spread from the site of elaboration, and that it has acted upon the capillaries throughout the body, including those in the skin.

The fact that rabbits can be quickly killed by intravenous injections of small quantities of concentrated and highly purified erythrogenic toxin is sufficient evidence that the toxin is not limited to its action upon the skin. Autopsy findings reveal nothing more startling than a similarity to fatal human cases of fulminating toxic scarlet fever, if one excludes the signs of local infection in the latter. Some animals show no pathological signs either in the gross specimens or on microscopic section, while others have undoubted signs of cardiac edema. The presence of albumin in the urine, which often occurs even in moderate human cases, indicates toxicity of the renal capillaries.

With our present knowledge none can say whether, in the average attacks of scarlet fever, the capillary injury in organs well supplied with these vascular elements (heart, kidneys, liver, lungs and brain) might not be permanent in nature, and might not add a substantial sum to the total organic injury that occurs from various causes during a lifetime. Negation of the possibility of lasting damage gives the patient the dubious comfort of theoretical objections instead of a chance for protection.

Can objectors to scarlet fever immunization maintain a tenable position in the face of clinical experience with scarlet fever antitoxin therapy? With the fact before us that the therapeutic effect of the antitoxin is almost solely due to anti-erythrotoxigenicity, contrast the average, moderately toxic case of scarlet fever at the time of antitoxin administration with the patient's appearance 12 to 24 hours later. Coincident with the fading of the external manifestations of capillary poisoning, the patient is transformed from a person, sick, hot, and disinterested in his surroundings, to one markedly improved, comfortable, and alert. If one can, by the use of scarlet fever immunization, prevent the patient from receiving the systemic insult delivered by erythrogenic toxin, the patient will have been done a great service.

Whether the prevention of scarlet fever will do the patient's community a disservice is highly improbable. If one takes the general Canadian carrier rate of Group A Streptococcus hemolyticus as being 15 per cent (in some urban surveys it has been found much higher), and if one increases the rate at one time by the annual number of prospective cases of scarlet fever, it would not reach

16 per cent. How significant this rise would be is conjectural. But the evidence presented by closed communities, such as nurses-in-training, indicates that scarlet fever immunization does not increase the number of streptococcal infections.

However, even if scarlet fever toxin were to be accepted as universally as diphtheria toxoid, it would be necessary to recognize its limitations. Were every person to be rendered Dick-negative it would not assure the disappearance of scarlet fever, for some rare strains of the causative agent produce erythrogenic toxins unneutralized by antitoxins elicited by immunization or, for that matter, by natural infection with streptococci producing the commoner erythrogenic toxin. Furthermore, all persons inoculated with the recommended five doses of scarlet fever toxin do not develop sufficient antibodies to protect their capillaries completely from the effects of the commoner erythrogenic toxin. This situation is comparable to the occasional failure of diphtheria toxoid to induce an immunity against an infecting dose of C. diphtheriae, although failures occur more frequently with the former than with the latter.

Yet none of these objections or limitations should be used as indictments against scarlet fever immunization, for the whole problem revolves about a fundamental principle of preventive medicine: whether it is better to depend upon naturally acquired immunity, and run the risk of permanent injury to the patient, or whether we minimize the risk by using the best available tools. The choice appears self-evident.

Preview

By special permission, we are privileged to bring to the readers of The Canadian Nurse the very stimulating discussion on "The Professional Status of Nursing" by Genevieve Knight Bixler and Roy White Bixler which was first published in the September, 1945, issue of the American Journal of Nursing. Their careful analysis of how well nursing measures up to appropriate criteria is well worth careful study.

The Problem of the Paralyzed Bladder

S. A. MACDONALD, M.D.

Paralysis of the bladder has always been and still remains a serious clinical condition. Any interference with urinary drainage whether from the kidneys, ureters or bladder is invariably fraught with dire consequences. These are due to the stasis of urine which inevitably results. Of the many sequelae which occur infection is one of the first to appear. It inevitably follows whenever prolonged obstruction occurs anvwhere in the course of the urinary tract. Sooner or later it is followed by back pressure damage which occurs in one or both kidneys depending on the site of the obstruction. Calculi are also prone to form above the obstructed area. If the condition is unrelieved the kidney substance and function are destroyed. If the damage is bilateral death eventually occurs from urinary sepsis or uremia.

All of these effects are associated with bladder paralysis. The inability of the patient to empty the bladder means that there is always left within the organ a pool of unvoided urine. This static reservoir leads to all the critical complications listed above. In this respect such a patient resembles the elderly man with an enlarged prostate, who similarly is unable completely to empty his bladder, and carries a persistent residue. Many of these patients, whether paralytic or prostatic, when questioned will say that they pass a normal amount of urine each day. Some will even claim to pass too much; in proof of this they will relate their day and night frequency. A fairly typical history is that of Mrs. X:

A white woman, aged 52, admitted with the following complaints; (1); Day and night frequency of urination—six months; (2) passage of malodorous urine—one month;

(3) hematuria — one week. Any previous urinary tract symtoms were denied. Fifteen years ago she received an uncompleted course of treatment for syphilis.

Examination revealed Argyll-Robertson pupils, absence of knee jerks and partial anesthesia of the legs below the knees. The bladder was distended to the umbilicus and completely insensitive.

A diagnosis of tabes dorsalis with bladder paralysis was made. The management of this condition and the control of the hematuria were the immediate problems. The patient was voiding thick, deeply red, foul-smelling, grossly infected urine. A urethral catheter was inserted and a constant bladder irrigation was begun. The bleeding rapidly ceased and the bladder urine quickly cleared. The bleeding had been caused by inflammatory ulceration of the bladder mucosa. The disagreeable odour had resulted from the infection of the bladder and the disintegration of blood clot within it. The diagnosis of neurogenic bladder was confirmed by cystoscopy, cystograms and cystometric stu-

In the hope that dietary deficiency with B avitaminosis might be responsible for the condition large doses of B-complex were administered but without effect. Parasympathetic nerve stimulants were also utilized but to no avail.

The patient had a completely flaccid, insensitive bladder which was incapable of contracting and producing normal urination. In such circumstances an ineffective type of urination can be produced by increasing the intraabdominal pressure. This is effected by contraction of the abdominal and diaphragmatic muscles. An over-flow type of micturition occurs but complete emptying of the bladder does not take place, and residual urine gradually accumulates.



Fig. 1. Normal bladder filled with opaque solution (cystogram). Observe smooth regular outline and oval shape.



Fig. 2. Patient's cystogram. Observe irregular outline, large size tapered fundus.

In this case it amounted to 2000 cc. Corrective operative procedures sometimes can be employed. The three most commonly utilized are permanent supra-pubic cystostomy, trans-urethral resection of the bladder neck and presacral neurectomy.

Palliative treatment was decided upon at least temporarily for this patient. She was instructed in periodic attempted emptying of the bladder and was also shown how to perform manual expression. By these means, combined with daily bladder irrigation and emptying, and the administration of urinary antiseptics, her general condition immeasurably improved.

This patient had what is known as an atonic bladder. Three distinct types of bladder paralysis are now recognized. These are: (1) The atonic bladder; (2) the autonomous bladder; (3) the automatic or reflex bladder.

In the atonic group, the lesion present interferes with the normal sensory impulses and destroys the spinal reflex arc. The bladder is characterized by low intra-vesical pressure and complete absence of any waves of contraction. A large residue is always present and

voiding is of the overflow type. The disability is usually permanent.

The autonomous bladder is the result of a lesion in the sacral portion of the spinal cord, the cauda equina the pelvic nerves (anterior sacral roots). There is resulting interference with the normal motor innervation of the bladder. Normal bladder contractions do not occur but feeble inefficient contractions do take place. They probably represent an inherent capacity of the smooth muscle of the bladder wall to contract, or demonstrate reflex mural activity. The bladder has increased tone and decreased capacity. Voluntary control of urination is lost and the resulting incontinence is both active and passive.

The automatic bladder is produced by a lesion of the spinal cord above the sacral level. In these cases the sacral arc, or so called micturition reflex, is intact. This type of bladder is characterized by decreased capacity, increased tone and waves of reflex or automatic contraction. All voluntary control of micturition is lost and most vesical sensation is absent.

In the presence of permanent nerve

destruction the clinical management of all three groups is unsatisfactory. In the case of Mrs. X, no recovery of bladder function can be expected. Her excellent response to treatment largely reflects the nursing care she received. These patients are all confronted with prolonged illness; many of them face permanent disability with more or less chronic invalidism. Their nursing demands are many and not the least of these is the need for cheer and encouragement. If there is an associated paralysis of the extremities, as in many war casualties, the need for skilled nursing care is still

greater. To maintain the patient's morale in such circumstances is a triumph of the art of nursing and, at the same time, to satisfy the patient's physical needs all the skill of the nursing craft is required.

Editor's Note: Under the caption "Using the Psychological Approach", Clara R. Aitkenhead has described the teaching opportunities which the case of Mrs. X afforded. How the nursing care resulted in improved morale in this patient is recorded on the Hospitals and Schools of Nursing Page in this issue.

The Care, Maintenance and Conservation of Hospital Equipment

W. J. COLEMAN

The long years of war when new instruments, materials, and equipment have been difficult to procure have put a severe strain on the supplies of these articles in use in the hospitals in Canada. This compilation of information will assist in keeping these things in as good repair as possible until replacements are available.

RUBBER GOODS

It is not necessary to dwell on the difficulties of procurement of the raw rubber at this time. Prominent authorities estimate that it will take at least two years after the Japanese are ousted from Singapore before there can be any quantity of manufactured natural rubber on the market. The British, American, and Canadian Governments set aside certain stocks for the restricted

manufacture of some hospital items, gloves, special urological catheters, Penrose drains, etc., but these stocks are meagre and every effort must be made to conserve what is in use. Firms are forbidden to sell either natural rubber gloves or synthetics to any but hospital and doctor customers. Other items than those just mentioned are mostly made of synthetics - generally Neoprene, but in the case of present day sheeting it may be almost anything. The most important item in the rubber group is gloves. Most of you will be using when possible the pure latex, sometimes just called "white" gloves, although all white gloves are not necessarily latex. These, if properly handled, are the most durable of all rubber gloves, but they have some characteristics which if not taken into account lead to very quick deterioration. First, if allowed to properly re-vulcanize after sterilization they will last a good deal longer than the cheaper varieties. The revulcanizing is not something for

you to worry about - the rubber will do it by itself, if it is properly dried after coming from the sterilizer and allowed to rest for at leasty twenty-four hours, forty-eight hours if it can be managed. Second, do not test gloves for holes by blowing up to any marked degree when wet. Let them dry after the initial washing and rinsing before testing. Latex rubber is weakest when wet. Consequently, the "ballooning" of fingers in testing results in many "pops" unless gloves are dry. Keep all rubber gloves from sunlight and when drying latex particularly, do not hang in front of an open window or on a window sill. The passage of cool air over wet gloves can and does cause the formation of small holes, like pin holes, particularly just at the base of the fingers.

Be careful in your cleaning. Soap and plenty of good warm water are indicated. If you wish, mild blood solvents can be used with good results. Do not use alcohol, ether or other spirits as these will also dissolve the rubber. Blood solvent will not harm rubber and will dissolve normal human oils such as a glove collects in an operation. Water will take off any of the better known "water soluble" lubricating jellies. Try to have your doctors use as little liquid petrolatum or vaseline as possible with gloved hands. All grease causes deterioration of rubber. One word about sterilizing, Go to guite a bit of trouble to keep your gloves away from hot metal. I suggest that when you place your glove envelopes in the autoclave, you place under them a towel or folded sheet to keep them well away from the metal tray or the sides of the sterilizer.

The next problem concerns tubing. Most of what is in use now is stiffer than the old stock. This means that it is built up with a greater percentage of filler — foreign material — or it may be synthetic. It is also more brittle. Rubber tubing, even when the best is procurable, should always be stored in a loose coil — never folded. With the

new material this coiling should be done with even more care. Coil also when sterilizing, either around large wooden spools or, as some hospitals do, have flat boards fitted with a number of pegs in a circle so that the tubing can be coiled around them. This also helps to keep the tubing from touching the walls of the autoclave. Also, clean your tubing carefully, inside and out. The Red Cross Blood Donor Clinics used blood solvent routinely for this purpose.

Rubber catheters. It has always been advised that catheters should be stored flat and straight in special boxes or tubes or even in the bottom of a long drawer. Those available at the present time are practically all synthetic, as good or better than pure rubber, but more brittle. Keeping them flat is even more important than heretofore. These new synthetics are not as easily affected by grease as pure rubber but we would still advise the use of a good surgical lubricant rather than liquid petrolatum for lubrication. It is a much better lubricant and more easily removed when cleaning.

Rubber sheeting as available right now is all synthetic and of different kinds. It is stiff, the fabric separates easily. Never fold rubber sheeting. Always store it rolled around a stick or cardboard the full width of the sheeting. That old advice is very important with this new stiff sheeting. When you receive rubber supplies in your hospital try to store them as you would adhesive plaster, in a cool dry place. Too often store rooms in hospitals are located down near the furnace with overhead steam pipes making the store room excessively warm. Just a word about one other rubber item. You are familiar with the latex rubber operating table, stretcher and maternity table pads, commonly called Dunlopillo Pads. These pads need very little care and will last for years providing one precaution is taken. They are fitted with a tight envelope of rubber sheeting. This is on there for two reasons - one, of course, to keep the porous pad from becoming soaked with blood or other fluid; the other is to protect the pad itself from light and air. When you find this rubber sheeting envelope badly deteriorated or torn, please replace it promptly. Otherwise your good Dunlopillo Pad will turn into a sort of gray dust in a comparatively short time.

SURGICAL INSTRUMENTS

Scissors, forceps, retractors, etc., are somewhat of a problem these days difficult to procure, expensive and not always of high quality. Also, there is a decided trend in recent years for hospitals to buy and supply them rather than for individual doctors to have their own. With all these things in mind it becomes increasingly important to conserve what we have. It is recommended that hard scrubbing to remove tissue and blood be curtailed to the minimum conducive to aseptic conditions. Try not to leave instruments too long with blood dried on them. Bland blood solvents can be used in a good many cases to obviate scrubbing at all. Hard scrubbing tends to wear locks, lift plating and dull cutting edges.

Locks of artery forceps and needle drivers require special attention. Box lock instruments have a tendency to tighten and consequently stiffen if the trouble is not corrected. When this occurs a doctor or nurse, when under the nervous tension associated with the performance of a difficult operation, may impatiently attempt to force the instrument and in doing so spring or bend it permanently out of line. Locks can be protected to some extent by thorough cleansing and proper lubrication with some good light-weight lubricating oil - and once again not mineral oil. Several hospitals use "three-in-one" oil. This is good and there are others that are just as satisfactory. If a lock does develop a condition of tightness or binding it should be immersed in a medium strong solution of green soap and gently opened and closed until the corrosion is worked out. Then immerse it in oil and use the same process of gently opening and closing it until it works smoothly.

Screw lock instruments are also subject to lock trouble but instead of tightening they tend to loosen. Proper cleaning and oiling is also indicated with them, but when they get loose you would be well advised to have them repaired without delay as a loose lock will mean poor occlusion of both ratchets and teeth and consequent excessive wear.

To sum up, clean all instruments thoroughly and with as little abrasion as possible, oil carefully and keep all in good repair. The old adage "a stitch in time" has never gone out of date.

Some months ago a scalpel blade sharpening service was offered to the hospitals and medical men of Canada for all makes of detachable blades. The machinery for this processing was very expensive but apparently very efficient. The firm that undertook to supply the service sent one of their best men down to the United States to find out how to perform the operation and also how to set up and service the equipment needed. Most of the large hospitals in Canada, together with the leading surgeons, have already availed themselves of the service with apparently entire satisfaction. The cost of sharpening and reconditioning these blades is something less than one half of the original cost of possibly the best-known detachable blade. Surely this is real conservation of metal and labour.

STAINLESS STEEL WARE

Included under this heading are bed pans, kidney basins, sponge bowls, etc. You probably have in use in your institutions a certain quantity of it, and are doubtless planning to equip more completely when a further supply is available. Stainless steel is undoubtedly the most durable type of all utensil material but there are some misconceptions about its complete indestructability. It is subject to dissolution and consequent pitting when exposed to certain chemicals. One of the largest manufacturers warns against solutions of Zonite, Iodine, Dakin's Solutions, Hygeol, Mercuric Chloride, Bichloride of Mercury, Hychlorite, Corrosive Sublimate and Sodium or Calcium Hypochlorite, advising never to leave them in contact with stainless steel for more than six hours. If there is danger of damage at six hours there is undoubtedly a lesser danger for a lesser period. Also as mercuric compounds seem to be the chief offenders, we should add to the list of "be careful" items two well-known trade name products -Abbott's Metaphen Compounds and Lilly's Merthiolate Compounds. When it is necessary to use any of these solutions we suggest that you use them for as short a time as possible and then wash and dry thoroughly after each exposure. Stainless steel is a solid metal alloy and if kept well scoured will keep its bright surface and last for years.

Hypodermic Syringes and Needles

One of the chief causes of syringe breakdown is sticking. Immediate and thorough cleaning after use can obviate this to a great extent. Good solvents are again of value in this process. Syringes are in short supply. By all means treat what syringes you have with added respect for the next few months.

The hypodermic needle supply situation is much the same as syringes — short, very! A good many sizes that were formerly made and used are no longer available, but there are, in most cases, substitute sizes which are fairly satisfactory. Because of this during the

past several years there has naturally been consideration given to the advisability of re-sharpening used needles. Two methods are available. One by the use of an electric motor operating a high-speed emery wheel. In the hands of an experienced operator this results in hollow grinding comparable with the initial factory precision job. The equipment is quite expensive and hardly feasible for the 'small institutions. The other method is by hand on a small soapstone. It is not nearly as successful as the emery wheel process and the time involved makes the cost almost prohibitive. However, this method can in some cases remove "hooks" on needles that would otherwise have to be discarded. It is important to learn the proper angle at which to hold the needle to the stone.

EQUIPMENT AND UTILITY SERVICES

Possibly the most expensive and important single unit in the hospital is sterilizing apparatus. As manufactured in modern times it is comparatively trouble free and self-operating. However, that does not mean that it should be expected to go on year after year giving good service without some care. All machinery needs periodic checking up and adjustment. There are only a very few points on a sterilizer battery or on a bed pan sterilizer that need oiling, but all hinges should be lubricated occasionally to effect easy operation and to eliminate wear. On the initial installation of equipment you have every right to expect assistance and supervision from your supplier, and possibly for six months thereafter. However, it is hardly fair to expect such supplier to keep on giving you service for years. Your own engineer should undertake to keep all valves tightened, replace valve seats when necessary and clean steam traps. This last chore incidentally is something, on an autoclave particularly, that should be done

routinely, possibly every three months, as most cases of poor dressing sterilization are definitely attributable to a steam trap that is not working freely. In one hospital with which I am familiar there is a regular contract with a local plumber for a complete check-up of all plumbing every three months, and this also includes all valves, steam traps, fittings, etc., on their sterilizers. That same hospital, incidentally, has a contract with a local electrician for a monthly check-up on all electrical service, including such things as operating room lights, quartz lamps, diathermy machines, electric food conveyors and so on. They believe that they save money by so doing.

One more thing about sterilizers. You all know the appearance of the pre-war instruments which were beautifully plated either with nickel or chrome. A good many executives have asked what to use in cleaning them. I can only pass on to you the advice of the manufacturers and this goes for any plated surface. They all advise "Bon Ami" and not substitutes. Brightly nickled or chromed sterilizing apparatus has not been available for some time, but if you have in your institutions some equipment of wartime manufacture it is considered just as durable as pre-war, and frequent polishing will very likely in time improve its appearance. Most finishes supplied at present are either "Matte" finish stainless steel or Everdur metal. Bright plating will, of course, eventually come back.

Keep the burners of quartz lamps clean. Dust or finger marks left on it will imbed in the quartz and stop emission of rays. Use a dust cover when not in use. See that electrical contacts are kept clean. Do not move the apparatus when lighted.

For diathermy apparatus or short-wave equipment use a dust cover. Be sure that electrode connections are kept clean. Periodically the cover should be removed from the back, or top as it may be, and the interior cleaned with a vacuum cleaner, being sure not to bend or displace contacts. An accumulation of dust

can cause a short circuit and fire.

On basal metabolism apparatus once again use a dust cover. Remove and dry valves periodically. After every three or four tests drop the patient-ends of the breathing tubes to the floor to allow condensation water to drain out.

There are several different kinds of baby incubators and resuscitators and with different characteristics. Generally it is advisable to have your incubator drained of water — if it uses it — when not in use. If you use a Heidbrink resuscitator, a dust cover is again of advantage to protect the flowmeters.

Operating tables. The ordinary low priced table needs very little care although a little oil or grease on all moving parts is once again very useful. Hydraulic tables on the other hand do need periodic attention. Most of them, for the first two or three years after they are put to use, need only to be tightened and to have the odd oil-hole filled. After that, however, there are leather washers or gaskets to be replaced, the oil in the pump should either be replaced or removed and filtered then returnd to its cylinder in the base of the table. There are adequate instruction manuals for all these procedures and if you haven't one on file covering the tables in your hospital I would suggest that you procure one so that when it is needed your engineer can undertake an overhaul job without delay. I wouldn't say that overhauling one of these big hydraulic (or oil-o-matic as they are sometimes called) machines is an easy job, but it doesn't need an expert. Patience, a strong back and a little common sense are all that is needed.

Gas anesthesia equipment is to some extent an item apart, in that the doctor using it is generally a trained anesthetist and has his own ideas about care and maintenance. Consequently, I will not touch on the subject except to tell you that there will undoubtedly be a greatly increased number of them in use from now on and that possibilities of getting expert service for them will be improved.

From One Post-War Period to Another in Canada and India

EDITH BUCHANAN

Then the war cut across the face of progress in hospitals and nursing, not in 1939 nor for the first year or two, but increasingly and progressively in the next years. Finally it underlined so clearly the vast need for nursing in India, that it forced attention and brought far more study of the problem. A very few facts and figures may help to show the magnitude of the health problems and the need for nurses in India.

In India the death rate is twice that of Canada and the maternal and infant mortality rates are high. The average expectation of life at birth is twentyseven years (as compared with sixty in Canada).2 Preventable causes, including communicable diseases such as malaria, dysentery and diarrhoea, cholera, small-pox, typhoid, plague, etc., account for well over three-quarters of the deaths.3 One half of the deaths are in children under ten years of age due to poor nutrition.4 Deficiency and nutritional disorders are marked and add to the common and severe anaemia found among women and children.

India is a tropical country with some of the greatest variations in temperature and in rainfall in the world. Tropical diseases are, therefore, found. Student nurses, for example, have to study a whole section in medical nursing which we in Canada have not had to consider at all. Further, the health of a community, as Dr. Grant points out, depends upon social and economic conditions, on education, and upon the public health services.

First then, something about social conditions. In India, not counting the native states, there are over 247 persons per square mile as compared with 5.74 in Canada (excluding the N.W.T.)

The increase in population has been 15 per cent in ten years, or over four times the total population of Canada.6 More than three-quarters of the population make their living by agriculture. Certain social customs prevail which spread disease, such as bathing in and drinking the same water, using the banks of streams, rivers and roads for defaecation, and floating imperfectly cremated bodies down the rivers. Seclusion and early marriage of women, together with hard physical toil among working women, produce a high female mortality between ten and twenty years. Secondly, the average annual income is Rs. 65 (about \$15).7 And thirdly, the literacy figure is only about 12 per cents. This is complicated by the number of dialects which the census quotes as 222. About a dozen of these are distinct and separate languages.9 Finally, India has some 42,000 doctors and some 7000 nurses 10 (one nurse to 56,000 population). In most western countries there are about two nurses to a doctor. There are almost no public health nurses.

The war has brought an increased study of figures such as these. It cut across the face of nursing progress, as mentioned above, and hit the hospitals badly. Many of the more highly qualified nurses joined the army. Indian nurses, who had been going abroad for special advanced training, were unable to go. No more persons with training for positions of responsibility were available from Europe or America. A large proportion of the staff nurses, not a great number in all, went to army hospitals. Schools of nursing and nurses' homes suffered badly. The quality and amount of teaching and the quality of the residential life deteriorated.

The many opportunities for joining auxiliary nursing services and service corps, such as the W.A.C.I., at better salary than that of qualified staff nurses and sisters, all tended to reduce the number of applications to schools of nursing.

Some leaders, however, had been alive to these trends and worked continuously for nursing. Some sister tutors (instructors) who applied to join the army, were asked to stay at their posts, and sister tutors in the army were given special teaching positions to give further training to those of the auxiliary personnel who wanted to qualify as nurses. Finally the appalling lack of nurses for army and civil population alike began to come home to all and sundry. The Trained Nurses' Association of India (T.N.A.I.) had been hammering away, just as the C.N.A. has done for years, at getting improved nursing education as basic for getting more and better nurses. For some years a School for Graduate Nurses had been planned, and some funds raised towards an endowment. A curriculum had been drafted in readiness. Finally in April, 1943, the army need for short wartime courses in administration made it possible to open such a school, half under military and half under civilian auspices. The Department of Education, Health and Lands of the Government of India sponsored the preparation of instructors of nurses for civil hospitals, and the army sponsored short three-month courses in administration for Indian military matrons and assistant matrons. Lady Linlithgow formally opened the School of Nursing Administration in part of the big Health School in Delhi. Sir Jogendra Singh, the Minister of Education, Health and Lands, participated, as also did the directors general of Civil and Army Medical Services in India.

We started with small groups in the school — six sister tutor students (instructors) and six army students in ad-

ministration. (These last changed every three months). Just two of us formed the internal or permanent staff - Miss M. Craig of Johns Hopkins, with her Master's Degree from Columbia, as director, and myself as sister tutor and assistant. We were able to draw on highly qualified external lecturers from Delhi University with its various colleges, from the Lady Hardinge Medical College, from the Army Nursing 11 and Army Nutrition Headquarters, from the Lady Reading Health School and Central Government Maternity and Child Welfare Bureau.12 The aim in the instructor's course has been to make the work taken of university standard. The city hospital schools of nursing and the health school and services provided observation and practice fields. Practice teaching in two languages was done in five different institutions. Two civilian and two military hospitals (the Indian and British Military) provided practice fields for the courses in administration and the American Military Hospital was visited.

Our army students had been in hospital behind the front line, some had been torpedoed, some wounded. All had had to cope with stupendous problems of supply and organization and an utter lack of trained personnel. It was a privilege and a humbling experience to work with them.

The student teacher group was com-



Lady Linlithgow talking to the children in the Health Centre.



The first students at the School of Nursing Administration when it opened in April, 1943, with Miss Buchanan.

posed of representatives sent by the different provinces of India. During the first year some were Indian, some Anglo-Indian and some European. The group this last year has numbered fifteen, including one qualified male nurse, and is, almost entirely, an Indian group. Again the problems that these young instructors are having to cope with are exceedingly heavy. Much is needed and expected of them, and not nearly enough help and wise guidance is available as yet! All the traditions are still to be built. But they are the beginning of a foundation built in India itself for the future. Trained in India, knowing the language and the problems, and teaching Indian nurses you may imagine with what high hope we see them go out all over India. One of these days there will be a Florence Nightingale, a Miss Nutting or a Flora Madeline Shaw among them.

Just as the last post-war period saw the opening of all our Canadian University Graduate Schools of Nursing, with the great development of teacher-training and the wide introduction of teachers into schools of nursing; of public health training; just as it saw the development of combined university and hospital schools, and then the development in the United States and Canada of the complete independent school of nursing in the university, giving and controlling the complete and all-round basic training course in nursing — so this post-war period is going to be of immense importance to India, to Canada and the United States and the whole world. If we are ready for it and know what we want, we can guide and crystallize public interest in nursing and use the post-war momentum to accomplish our dearest hopes for the future of nursing.

In India then, as elsewhere, we are commencing a great period in nursing. We are aiming at a million nurses in thirty years (to give one nurse per five hundred population). The Trained Nurses' Association of India is appealing to every Mission Board to help in more and better training of nurses, improvement of schools of nursing and nurses' homes, development of public health work of every kind. We are asking every nurse who goes to India from a Western country, however she goes, or under whatever auspices, to prepare

herself with the best that her country has to give. She must give far more than a part or mere portion of what she got. She must read and study and learn so that she can pass on more than she received. Those of us who graduated a few years ago have the advances and developments in health and preventive work, of recent years, to master. Everyday nursing is progressing. No Western nurse in India can escape heavy responsibility for improving nursing education, for broadening nursing to include its rightful health and preventive aspects, and for working towards a sound scientific and professional preparation of nurses in India.

Further, there are now a good many Canadian, American and British nurses who know India, perhaps from a childhood spent there, or from army or other experience. This is a group who have a special contribution to make if they will prepare especially as teachers and public health workers and come to the India they loved as children, to build up nursing in the post-war period. Some definite affiliation such as a mission board, an international health service, or family or connection in India is very necessary. Some positions just have to be worked into. Remember that you may spend four or five years paying back a debt due to sickness liabilities in your first year out if you do not have some defin ite arrangement or affiliation. It takes a year or two to adjust and build up immunity and a healthy routine. However, since India is very dear to many of us, and since we have the knowledge of the past and an ear for the language, we have an understanding and affection which helps us to see promise and to see clear and possible lines for advance.

Right now there is very great hope of Independent Collegiate Schools of Nursing being started in India for the basic and all-round training of public health nurses. The T.N.A.I. has worked for one in Delhi for some years and hopes that it may be established with the post-

graduate school very soon. Already also the missions co-operating in the National Christian Council in India are working to establish a school affiliated with Madras University at Vellore. Various Indian universities seem to be interested in setting up collegiate schools. The difficulty is to get the matter so soundly based that both university and nursing may benefit and prove an enrichment each to the other.

A thoroughly sound way of being sure that the teaching of the subject of nursing is improved is to get complete educational control by having the school financially independent of the hospital, by putting expert nurse educationalists in charge, and by using hospital and public health fields for practice, that is, for the practice necessary for learning, and not all the repetitive work necessary for servicing as such. This means that money is needed — an endowment, or state, or university support — for the getting of which the post-war period provides a great new opportunity.

An equally sound and thorough way of being sure that we, as nurses, really do get a full university education, with nothing "ersatz" about it, is to fulfill the complete university requirements for a Bachelor's Degree in Pass Arts (quite over and above any purely nursing or clinical subjects), taking liberal subjects and choosing biological and social sciences related to nursing. For example, this might mean entering the university with senior matriculation (thirteen years of schooling) and then taking fifteen academic courses ordinarily spread over three years of eight months each (twenty-four in all). In addition to this, however, the honour subject of nursing, with all its related clinical subjects, would be added and integrated very carefully with the biological and social sciences, and then the whole would be spread out to cover a period of four full years (forty-four months when holidays have been subtracted). This means that in the four-year period a clear twenty

months are used for nursing subjects with co-ordinated practice. In addition, nursing as the honour subject, or specialty, is taken closely co-ordinated with other subjects throughout the whole four years as any honour subject would be, no more and no less.

Another method which involves the same total years of schooling in the end is to enter the university with junior matriculation (twelve years of schooling), take two years of pre-nursing work at the university, including liberal subjects and certain required sciences such as biology and chemistry. The student then enters the nursing school in the university. There she takes further biological and social sciences basic to nursing, and nursing itself as the major subject with all its clinical branches in a course of thirty months. This is followed by a "staff student" or senior cadet period of six months.14

And so after eight years in India it has been wonderful to be home in Canada this year. I have been studying the Independent School of Nursing (under a Rockefeller Fellowship granted at the request of the Government of India). I hope to be able to put it all to the most thorough use, by helping in the building up of an Independent School of Nursing in India.

No one who has studied the Independent School seriously can fail to realize the great educational advantages first, to nursing and nursing education, giving educational freedom and an intellectual approach in the teaching of the actual subject of nursing itself; second, to nurses as all-round and socially minded individuals; and third, to the community, making possible a broader and a more highly specialized contribution to its welfare. As nurses, we need an intellectual and scientific preparation to enable us to contribute that share in the planning of the post-war period for which we are justly fitted by broad social experience. Just as Canada has played such a real part in the development of the modern independent school so now she needs to lead the way in perfecting it in various different forms, and in using it far more widely. Canada needs a great number of different types of Independent Schools of Nursing — endowed hospital schools, state-supported and university schools. In short, no nurse can afford to be blind to the clear-cut educational advantages that other professions — having had independent professional schools for many years—have so long enjoyed. No nurse can afford to neglect this postwar period to try to make up the deficiency.

It is a proud matter for us, who travel away from home, to hear of Canadian nurses in the forefront of modern developments. We will watch with special eagerness the accomplishments of Canada in this great new era before us.

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11. Mrs. Wilkinson, now in charge of the Queen Alexandra Imperial Military Nursing Service, was then in charge of the Indian Military Nursing Service, and did a great deal to help in starting the School of Nursing Administration.

12. Dr. Jean Orkney, officer of Maternity and Child Welfare, who helped us very

greatly, visited Canada and the United States on a Rockefeller Fellowship only a few years ago and will be remembered by many Canadians.

13. Nursing Journal of India, Feb. 1945.

14. Both students and staff at the School of Nursing, Vanderbilt University, are enthusiastic about the senior cadet period.

Central Supply Room

DOROTHY L. WARD

With the increasing shortage of nurses and in an earnest desire to maintain adequate nursing service a Central Supply Room was organized in the Homoeopathic Hospital of Montreal, in November, 1942. Such a department conserves both time and material and ensures better standards of performance. It was felt also that this department would relieve the ward nurses of many mechanical duties thus allowing more time for bedside nursing. The head nurse, too, is relieved of the responsibility of care of equipment, thus givin her more time for ward supervision and the many added duties which have become her lot in present times.

In the spring of 1942, a survey was made and it was decided that a ward dressing room and a service room, situated on the top floor of the hospital near to the operating room would be suitable. New cupboards with adjustable shelves were built into the dressing room now known as the Dispensing Room. The service room was equipped with a deep sink, a two-burner gas stove, and a large hot water sterilizer. To this was added a long work table with large drawers underneath for unsterile supplies, and a cupboard above for linen, enamel ware and other supplies. This now is the Receiving Room.

In the Dispensing Room only ster-

ile supplies, clean equipment, and solutions for intravenous use are kept. A Dutch door, the lower part of which is always closed, bars entrance to those other than the Central Supply Room staff. All requests for trays and equipment are made on a special requisition, called an order form, by the head nurse and presented to the Central Supply Room Dispensing Room. The order form contains the name of the ward, date, article requisitioned, and signature of the head nurse. In cases when a charge is to be made, the patient's name is added to the order form which is then sent to the business office. To each tray in the Dispensing Room is attached an isinglass covered card and a service slip. The card contains a list of the articles on the tray. The service slip contains the name of the tray, the signature of the nurse who set the tray up, and the date of sterilization. There is space on this slip for the ward, ward nurse's signature, and date on which tray was used, also space where any breakages, defective or missing equipment may be noted.

The Receiving Room, as its name implies, is the section where all trays are received after they have been used on the wards. Cleaning, sterilizing and assembling of equipment is carried on here. As the trays are taken in, the ser-

vice slip, completely filled in by the ward nurse, is removed from the isinglass covered card and kept for twenty-four hours to be checked against the order form. Once every day an entry of all trays issued from the Central Supply Room is made in the daily census book. This book acts as a permanent record of the trays used, the number, and to which ward they were issued. At the end of the month these entries are totalled and the average number of trays used each day is ascertained.

The Central Supply Room in the Homoeopathic Hospital (120 beds) is set up to service all wards and departments except the obstetrical ward. All treatments and examinations, instruments for dressing trays, surgical supplies, needles and syringes, croup tents, bed sides, restraining belts, and jackets, electrical equipment, such as fans, heaters, and thermolights, sand bags, fomentation flannels, ice caps, ice collars, and rubber air rings are kept in the Central Supply Room. Equipment for oxygen therapy is dispensed from here. In this hospital oxygen therapy is administered by means of the nasal catheter and B.L.B. mask and student nurses receive instruction in this important therapy.

A graduate nurse is in charge of the Central Supply Room during the day. After 7 o'clock, the night supervisor receives all calls for trays, etc., and dispenses them. There is one student nurse in the department. She spends a period of three weeks some time after the completion of the junior operating room term. A junior student being trained in the care of anesthetic patients in the post-operative recovery room works in the Central Supply Room in the after-

noon. This student spends five hours five days a week in the preparation of solutions for ward use. Such solutions as carbolic solution 5 per cent and boric solutions 4 per cent, etc., are made under supervision.

The advantages of the Central Supply Room are many. First to the teaching program it is a link between the classroom and the ward. The travs are set up for ward use in the same way as the procedure is taught and demonstrated in the classroom. This standardization has proven helpful to the head nurse and student alike especially in this hospital which is an open hospital with doctors making rounds throughout the day. To the student nurse the uninterrupted period of three weeks when she can learn the proper care and sterilization of equipment used in the hospital is an advantage over the former, often hitand-miss, way of cleaning travs and equipment whenever she could make the time. Centralization of equipment lessens duplication of supplies thus proving an economy in the operation of the hospital. Equipment lasts longer when properly cared for, therefore, replacements are fewer. To show how breakages have been cut down, the greatly used 2 cc. hypodermic syringe is an example: the breakages in February, 1942, amounted to 14, in February, 1945, to 4. Similarly, replacements due to breakage in all articles have been reduced, so that it is felt that the initial cost of building cupboards and buying new equipment has been made up by this great saving. And to the patient - he, too, benefits by this wartime measure since centralization and standardization make for better nursing service.

Preview

Who is responsible for what in the total picture of welfare work in the community? When should the public health nurse refer cases to the social worker? What may she look for in collaboration

from her colleague? These are some of the baffling points on which Lillian Thomson will throw light in her forthcoming discussion on the Public Health Nursing Page.

HOSPITALS & SCHOOLS of NURSING

Contributed by Hospital and School of Nursing Section of the C. N. A

Using the Psychological Approach

CLARA R. AITKENHEAD

One of the secrets of success in clinical teaching and supervision lies in the type of approach and contact which is made between the patient and supervisor or head nurse. In the smaller school the nursing arts instructor often assumes some responsibility for the ward teaching program which, if well planned, should provide considerable satisfaction. There is a definite advantage in having the same person perform this dual function, since she can perhaps better correlate theory and practice than the busy head nurse of today who lacks time because of heavy administrative duties and may not always be qualified to assume this very important part of the student's education. In contrast to "Mrs. Chase", the patient provides the necessary stimulation for the students, and the instructor can measure the effectiveness of her classroom teaching.

There is usually some degree of apprehension on the part of the patient on admission. If it can be overcome by a satisfactory contact we have a valuable aid to efficient nursing and are assured of a favourable reaction. In the busy routine of a hospital day nurses are often too prone to forget this very important aspect; what appears simple to the student can seem complicated to the patient and arouse unnecessary fears. A few minutes spent in reassuring the patient will prove well worthwhile,

What are some of the factors that help to make a good contact? First, a friendly yet impersonal attitude. Normal individuals respond well to an interest in themselves and the sick are no exception. Dr. Osler, has said it is sometimes more important to know what sort of a person has the disease than what sort of disease a person has. The nurse should show a real interet in the patient as a person, his or her occupation, family, names and ages of children, who is caring for them, previous visits to hospital if any, interests and hobbies. This in many instances is all that is needed to break down any barrier that might exist between patient and nursing staff. It is important to learn from the patient if he has any fears, worries or questions in his mind and the nature of them. Such questions as can be answered by the nurse should be done intelligently, others should be referred to the head nurse or doctor.

Having attended to the mental comfort, emphasis is then placed on the physical well-being of the patient. In the presence of a skilled, understanding supervisor a feeling of security and confidence is built up in his mind. Small details in nursing care, which add immeasurably to comfort while a treatment is being performed, are too often forgotten.

Special interest should be shown in

DECEMBER, 1945

the patient's physical condition, ascertaining what factors led up to consulting a doctor and why hospitalization was necessary. Some brief explanations to the patient are essential in order that he may fully understand. An outline of the prescribed treatment, what he can do towards his recovery and welfare, and the part nurses and doctors play — are all topics which can be discussed.

Students learn by various methods classroom instruction, the morning circle,3 conferences, ward clinics, patient care studies, clinical teaching and supervision4 — the last mentioned being one of the most effective methods when carried out by a qualified supervisor who is keenly interested in the welfare of patients and in stimulating students to do good nursing. Observation of a nursing procedure well performed is important in the learning process, but learning by doing under proper supervision is even more important in order to develop skills. Here with a patient the young student sees and learns to meet the physical and mental needs more intelligently, to discriminate and thus use better judgment. This patient-nurse relationship also helps to foster desirable attitudes in the young student, so essential to good nursing. At the bedside the value of organization of equipment is more fully realized, nursing skills as taught in the classroom are put into practice, new techniques aer learned and mastered and, what is so often forgotten, opportunities to teach the patient present themselves. Patients who may have to do treatments at home have many questions to ask. How dependent the patient can be on instructions from a good nurse, in a way that he can understand, cannot be over-emphasized.

A great deal of the success in clinical teaching depends on the ward demonstrations being performed as soon as possible after the classroom demonstrations. In order that clinical supervision may be most effective, the student must be well prepared prior to per-

forming at the bedside. She must have a thorough understanding of the nursing principles involved, the type of person to whom she is giving care, particularly from a psychological point of view, special precautions to take and whether or not there are specific needs to be met. The head nurse, who usually knows and understands the patient much better than the teaching supervisor, is a well qualified person to give this information.

When a demonstration is being given, the number of students who should be at the bedside will depend on several factors - the kind of patient, degree of illness and the nature of the procedure under discussion. When it is not considered feasible for a group to be present, having not more than two students at the bedside who will act as assistants helps to remove the feeling in the mind of the patient that she is being used merely as learning material. In some instances it may be considered wise to have only one student observe. If the nurses are well prepared beforehand no discussion of actual technique should be necessary at the bedside. After the demonstration by the supervisor a student who has observed carries out the treatment the next time it is due while another one looks on. While the nurse is concentrating on her technique the supervisor keeps an eye on her, and also talks with the patient, thus helping to relieve tension both on the part of the patient and the student. It is a good plan to have a third nurse responsible for the physical preparation of the patient such as draping, protecting and screening bed, adjusting light, etc., but she does not observe the procedure at this time. This allows each student to concentrate more fully on her allotted nursing care and also saves time. Later, when the student has acquired more confidence through experience, supervision of the entire procedure, including care of the patient, can be carried out. As compared with the initial performance when the student is

primarily interested in technique, the supervisor at this time can evaluate her progress and the teaching will be more effective.

If it is possible to have students perform certain treatments for the first time while they are still in the classroom, better results will be obtained since the time element is removed, as compared with the nurse who is being supervised when she is on the ward full-time and is responsible for many additional duties.

When the treatment is completed, the physical comfort of the patient taken care of, appreciation expressed for her co-operation and the equipment removed from the bedside, there follows a short conference and questions on various aspects of the procedure. The sun porch on the ward or the classroom, where the students can be seated, is a suitable place for this discussion. Reporting to the head nurse and charting completes the procedure.

Let us consider the teaching opportunities that were afforded by Mrs. X who has been admitted to a ward in the hospital, a slightly-built woman of fiftytwo years, with two boys in the services, her husband and young daughter at home. She appeared very weary and listless when first seen, somewhat apprehensive but most willing to co-operate and very appreciative of the nursing care being given. Her condition is more fully described in Dr. MacDonald's article in this issue of the Journal. Daily catheterization and irrigation of the urinary bladder was prescribed, using 500 cc. of warm 4 per cent boracic solution. At first, as much as 1500 cc. of cloudy urine with a foul odour would be withdrawn. Then the doctor asked that she void just prior to the treatment. She would pass from 300-500 cc. and when catheterized the nurse would obtain 1000-1200 cc. of cloudy urine with a thick sediment at termination. As the infection in the bladder cleared up, the patient's appetite improved and she slept better. The amount voided at one time gradually increased, the urine appeared more normal, and the amount withdrawn on catheterization was as low as 500 cc.

While she was in hospital one of the sons returned from overseas and visited his mother. Mrs. X was very happy and on seeing her the next morning stated she could not help but feel that the mental state of an individual had a marked effect on his physical condition. The physical response to the psychological stimulus was that she started voiding unusually large amounts, and on the day following the retention was considerably less for the first time. Our patient looked an entirely different person; it was easy to see that she had been relieved of some mental strain. While it is well realized that we cannot separate the mental from the physical state, so definitely does the one affect the other, the point the writer wishes to bring out is that this comment coming from the patient spontaneously is of significance and bears out our premise. The atmosphere in the whole ward seemed brighter because of this one patient's cheerfulness, and the response to her daily treatments was most satisfactory.

Being of the same nationality the supervisor did not encounter any difficulty in gaining the confidence of Mrs. X and making a very desirable contact with a view to using her for teaching purposes.

A small group of junior students, who had not performed this procedure previously, were chosen to report to the ward three at a time on successive days, to carry out under supervision the daily treatment of this patient. This consisted of catheterization, collecting a specimen for laboratory examination and irrigating the bladder. Prior to the first demonstration a short conference was held with the students, telling as much as possible about the patient and her condition.

The supervisor performed the pro-

cedure once assisted by two students to whom we shall refer as A and B. After preparing Mrs. X mentally for the treatment B draped her, screened bed and adjusted light, while A observed the tray set up, scrubbing of hands, carried the tray to bedside and observed. The next day A performed the treatment, B observed while C draped the patient. The following day B performed, C observed and D took care of the patient. This rotation continued until all students in the group had carried out the procedure satisfactorily under supervision. The patient's confidence was so well built up by this time that she did not mind at all having a different student each day. So long, she said, as the supervisor was present she felt quite secure and the treatment was done comfortably and with safety. One of the values of teaching at the bedside is that the student learns to attend to simple details such as turning the pillow, giving a drink, and making the patient quite comfortable before commencing as well as leaving her comfortable when the treatment is finished. This is mentioned as Mrs. X expressed considerable appreciation for this care, stating that when the treatment was carried out in the absence of supervision, there was sometimes a lack of attention to these details - the draping would not always be adequate which she said was embarrassing, regardless of the fact that the treatment was carried out daily. This was brought to the attention of the students and emphasized in an endeavour to point out to them that, while this was all taught in the classroom, it was not merely something to be read and not practised, but really affected the patient much more than one would realize. Visualization in the learning process tends to make a favourable and permanent impression on the young student, and getting the patient well as comfortably as possibly must always be borne in mind.

At first very little actual teaching was

given at the bedside. We did not know how the patient would react to verbal instructions, although she realized the students were performing the treatment for the first time. Then one day Mrs. X said that she was learning, too, and was very much interested, saying that some day she might have to do it herself. From then on a simple explanation of the treatment was made to her as we went along. Mrs. X enjoyed meeting all the different students and looked forward to our daily visit.

When our patient was about ready to go home the doctor said she must carry out her treatments for some time, and that the nurse would teach her how to do it herself. She was rather perturbed about this, the kind of equipment to use and the preparation of it. She had noted how careful the nurses were about their technique and expressed some fear regarding her ability to do it safely herself at home. The tray set up, while simple to the nurse, looked most elaborate to her - where and how would she obtain all the enamelware, sterilize it properly and not contaminate anything? This was discussed with the supervisor who gave her the reason for the rigid technique employed in hospital, how simple utensils found in the home, when cleansed and boiled, would serve the purpose, as well as method of sterilizing the catheter. A simple but safe procedure was drawn up for home use and explained in detail, in addition to preparation of boracic solution for cleansing and irrigating, and bichloride of mercury solution for sterilizing the hard rubber catheter. This type of catheter was prescribed by the doctor since it would facilitate the treatment for the patient when doing it herself with less risk of contamination. We observed Mrs. X carry out the treatment twice with the aid of a mirror before she went home and she did it very well. It was a great satisfaction to the nurses to note how effective our teaching had been. Our patient felt very happy and relieved to

feel that it was not as difficult as she had thought, and expressed her appreciation for the nursing care, encouragement and instructions given.

While in hospital Mrs. X was taught the value of sufficient rest, sleep, freedom from mental strain, elimination, posture, a well-balanced diet and plenty of water, as applied to her particular condition. She was an intelligent person and responded very well to advice.

A visit to the home by the supervisor was welcomed by the patient to look over the home set-up to ascertain if it was satisfactory. It was a simple home, attractive and meticulously clean. The only expense Mrs. X had was for an Asepto syringe, catheter, absorbent cotton and bichloride of mercury tablets. For the tray she used a cookie sheet, two odd custard dishes for cleansing solutions - using castile soap and boracic - a wide glass pint-size jar for the irrigating solution, a quart milk bottle for the bichloride of mercury solution, and an oblong enamel pie dish in which she immersed the catheter for sterilization, rinsing it by pouring boiled warm water over it. She set her tray out in the bath tub, placed a bath mat on the bottom on which to sit, adjusted a hand mirror by placing it against the glass jar, then performed the treatment which she stated soon became as simple as cleaning her teeth. When finished she cleansed and sterilized the articles used. covered the entire tray with a clean towel so that everything was ready for the next morning. When seen at the clinic a few weeks later, our patient seemed an entirely different person, bright-eyed and happy about feeling so well and pleased with the progress she feels she has made.

Interest in the welfare of Mrs. X expressed by the students, led to an invitation from her to visit her home, where she said she would show them her tray and tell how she carried out the treatment. Keen interest and enthusiasm, was expressed for the simplicity of equipment, method of preparation of it, and performing the procedure. Many questions were asked and answered. Our patient seemed pleased over the inquiries made in regard to her health and family. We were shown through the home where some of her handicraft work was much admired.

On return to the hospital a short discussion followed regarding the close correlation between theory and practice, the value of teaching the patient, and, lastly, the satisfaction derived by the nurse on achieving the ultimate aim of nursing.

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An Instructors' Group that Really Functions

MARGARET O. COGSWELL

In the Edmonton District, Alberta Association of Registered Nurses, is a very enthusiastic "Instructors' Group". On the third Monday of each month, with the exception of the three summer

months, eighteen instructresses from the various training schools meet to get acquainted and to discuss problems. Members from the University of Alberta and from each of the four training

schools in the city attend, and nurses from Ponoka, sixty miles south, Vegreville, sixty miles east, and Lamont fifty miles northeast, come in by train or car or bus. We visit each of the hospitals in turn, and are always warmly welcomed. This has been going on for six years and, although the personnel has been continually changing, enthusiasm has never waned. Partly, it is because we start out with dinner at six o'clock -and such a fine dinner! Here we relax and let ourselves go and really get to know one another. Everything is discussed from the weather to the latest movie.

When dinner is over, we either gather around a long table or pull easy chairs into a circle. Paper and pencils are distributed and we start work. We have been very fortunate in our chairmen. People like Laufey Einarson, Gena Bamforth and our present leader, Mrs. Virginia Pearson, are all so interested, enthusiastic and capable that they guide us and keep us from straying from the paths of business.

In September, we usually decide what our program will be for the following months. This is very elastic and when anything new crops up it receives due consideration. However, we do try to plan at least a month beforehand what the topic of study will be so that each can be prepared.

Last year we started with a discussion of the R. N. papers. A report was given by members of the spring and fall panels regarding the methods of marking the papers, the allotment of marks and the evident weaknesses there had been in teaching. In turn, members of the group weren't backward in pointing out what we considered wrong with the papers.

Our chief studies for the year were the course outlines used by the different schools of nursing, two or three subjects being taken up at each meeting. The plan was as follows: One person would outline her course in, say, anatomy. She would tell us how many hours she gave, how this time was divided, what aids she used in teaching, and the relative merits of the textbooks she used. Then a teacher from each of the other hospitals in turn would give her ideas. Each told of the differences in her plan, why she found another textbook more valuable, etc.

In January, we invited the supervisors and head nurses interested in ward teaching to meet with us in the hope to correlate the work in the classroom with that on the wards. About sixty were present. To stimulate participation, four of the instructors opened the discussion with short talks on bedside teaching; treatments and drugs—their place in the ward teaching program. One of the highlights of the year was a visit from Miss Gertrude Hall from National Office in March. She introduced a number of revolutionary ideas that stirred us up considerably

During the summer we are to put some thought on qualifying examinations for students at the end of the first year. In the fall we plan to make a study of it.

There is always so much to discuss that if we hadn't a capable chairman we would carry on far past the usual 9.15 p.m. For six years no one has been known to miss a meeting unless illness or some other major disaster has overtaken her. Each one feels that these get-togethers are so worthwhile that everything else must be set aside for that evening.

Did you remember that nurse friend with a subscription to The Canadian Nurse as a

Christmas present? It is not too late to do it. We will send a gift card in your name.

GENERAL NURSING

Contributed by the General Nursing Section of the Canadian Nurses Association

Opportunities in a Rural Hospital

JEAN WHITE

One of the biggest problems in the present-day nursing world is to get and maintain adequate staffs in the hospitals located in the small, out-of-the-way communities. This difficulty is not peculiar to any particular area. It seemed worthwhile, therefore, to do a little analyzing and to try to discover the advantages as well as the disadvantages of nursing in a small hospital in a community remote from the large, well-populated areas.

Let us consider first why hospitals are organized in thinly settled localities. Where transportation between villages and towns and larger urban communities is difficult, to have ready access to a local hospital may mean the saving of lives. While a certain level of care can be provided in the average home, there are innumerable cases of illness which require the highly skilled care available only in hospital. Most hospitals are organized and paid for by the communities for the benefit of the community. A considerable amount of local pride is developed in having as much equipment and as many services available in the small rural hospital as can be provided. Organized on this basis, the hospital sells its services when possible to patients who are able to pay and gives service, which is paid for by the community, to those who cannot afford to pay. The hospital stands ready to serve the

sick as the agent of the community, looks to the community for support, and supplements public funds by charging fees to patients able to pay them.

It would appear, therefore, that there is ample justification for the establishment of small community hospitals. Who should give the nursing care in these institutions? Twenty years ago it was common practice to have a school of nursing conducted with student nurses providing the service. More recently it has been realized that, even where adequate affiliation facilities were available to supplement the training these students received, the arrangement was far from satisfactory. The community hospital was confronted with the problem of meeting the need for nursing care with a goodly proportion of their senior students absent from the home school. Gradually, as more and more of these small training schools have been closed, the call has gone out for graduate nurses to staff the wards. Tasks around the hospital which do not call for the skill of the fully qualified nurse have been delegated to ward maids and to nurses' aides. The war has brought in many of the latter, trained by the St. John Ambulance Association or Canadian Red Cross Society, who are capable of making beds, giving baths, and similar tasks which release the nurses' time for more technical services.

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The number of staff nurses required for a fifty-bed hospital fluctuates in relation to the volume of skilled nursing care needed. It has been estimated that "there should be enough nurses to give an average of somewhere between twoand-a-half and three hours of nursing care per patient per day". What advantages has this type of hospital to offer to the ambitious young graduate? How can she be persuaded to venture far from the larger towns and cities to the small hospitals where her services are so sorely needed? People speak of "being buried in the country". What has that country to give to the nurse who is interested in looking for a full life, rich in contentment?

Perhaps the most important factor is the breadth of experience which may be secured. In a large institution the staff nurse is usually limited to one ward. In the small hospital she must be prepared to assist with all types of care, operative or obstetrical, communicable or emergent. It is an excellent opportunity to broaden her knowledge of every aspect of nursing care. Here, too, the observant nurse can learn many of the details of hospital administration, supervision of the sub-staff, filing of records, accounting, purchasing and hospital housekeeping. A better understanding of the patient is possible because the nurse knows the type of home from which the sick person has come, the type of life she leads, the family responsibilities, the financial worries, the best methods of providing for successful convalescence. In matters of health teaching, because she is familiar with the racial groups in the community, their habits, diets, etc., the nurse can accomplish very real improvements. Certainly these are advantages, par excellence, which the nurse limited to one ward in a large city hospital can never enjoy.

In off duty hours, what has the small community to offer for recreation? Golf, riding, tennis, frequently swimming for summer leisure; skating, skiing, bad-

minton as winter sports. Nurses who enjoy a game of bridge will find interested friends among the townsfolk; those whose hobby is gardening will find ample opportunity and space. The radio makes up for inability to attend symphony concerts and plays. Do the majority of staff nurses in the large city hospitals go to them anyway? Book clubs, knitting clubs, nature clubs there is no lack if the nurse will look for it. There is a sociability to be found in the small town and the rural area which is entirely lacking in the large city. The nurse can belong. She is not simply one small individual on a big staff - she can become a part of the active community life.

One of the voiced stumbling blocks is stated to be the smaller salaries paid to the nurses in the rural hospitals. When she stops to realize how little actual hard cash the average farmer and his family handle in the course of a year, the nurse will understand a little of the problem the rural community has in financing the hospital. I am not attempting to justify inadequate salaries but experience has proven over and over again that, even though she may receive less than her city sister, the nurse in the smaller hospital is able to save much more in proportion. For the ambitious nurse who is anxious to go on to postgraduate work, there is no better way to put money in the bank than to seek employment in a rural hospital,

It has been suggested that a possible development in the future may be to reverse the former affiliation arrangements whereby senior students from the large schools of nursing might go for a few months to some of the smaller hospitals. There is considerable merit in this plan, particularly if there is a public health nurse in the community who could introduce the student to the homes of the people and familiarize her with rural psychology. Knowing the opportunities provided in these hospitals, the

(Concluded on page 970)

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses
Association

An Experiment in Group Study

HESTER LUSTED

Regina's public health nurses have been organized and holding regular meetings for ten years. Officially, we are Regina Sub-section of the Public Health Section of S.R.N.A., but we more often refer to ourselves as the "public health group". This group holds meetings the first Wednesday in every month from October till May at the homes of the members. There is a short business meeting, a program, and light refreshments are served so that we have a social get-together to finish off our evening. However, the program is the main part and each year a plan is drawn up in the fall. Last season we made a study of our community and it was one of the most interesting programs we have had.

As a basis for study we used Joanna C. Colcord's book, "Your Community", published by the Russel Sage Foundation. This book was specifically designed as a guide for citizens who wished to collect facts about their community as the basis for efforts to promote better living conditions and is especially valuable to groups interested in the field of social work.

As public health nurses we realize that living conditions are inseparable from health problems so we set out last fall to find out what sort of city this is in which we live and work. Before we had gone very far we felt a bit like explorers — there were so many previously unknown facts to be discovered about Regina.

Our guide-book started us off with an explanation of how to go about our fact-finding trips and it suggested that we keep a social base map of our own community. This is a large scale map on which are affixed symbols which indicate the location of various institutions and facilities — public services, schools, churches, clubs, welfare institutions, recreation facilities and so forth. After this introduction each chapter of the book is devoted to one aspect of community life commencing with founding and development, local government, and moving on through housing, provisions for health care, educational resources, to the final chapter on community planning and co-ordination. These are just a few of the headings. There are nineteen chapters, each one covering one phase of community life, describing its purpose and value to the community, then giving a series of questions which we had to answer for our own city.

Each member of the group was assigned one topic and usually two topics were covered at each meeting. First of all, the nurse studied the guide-book, then set out to accumulate enough information to answer the questions and make out a report to be presented to the group. This usually involved interview-

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ing one or more persons—the police chief the regional director of selective service, directors of social agencies — as well as making good use of the public library.

It did involve a good deal of time and work on the part of each member as she prepared her topic, but it was most certainly interesting work and every one of us felt that we could have spent more time and got more information on our assignment. By the time we came to the end of our meetings for the season

we felt that we had learned a great deal and would like to go on and become still better acquainted with community facilities.

Our only suggestion to any group undertaking a similar study is that they assemble their reports into some sort of file or loose-leaf book in order to have a permanent record of the information gathered. We feel that we could use such a book as a reference, and it would be especially valuable to a nurse commencing public health work.

Disease Incidence Up

Tuberculosis and syphilis are the two most important health problems of liberated Manila, according to Epidemiological Information Bulletin No. 15 released by UNRRA. Based on returns for the first three months of liberation, the death rate for pulmonary tuberculosis as for a year has been calculated at 800 per 100,000 inhabitants, or about twenty times that of the average American city. In ten weeks, 2,045 new syphilis cases were found among the civilian population, and the incidence continues to increase. Gonorrhea is equally prevalent, Manila was one of the few cities of tropical Asia where malaria had been reduced to a low level. During the Japanese occupation the disease returned and it now constitutes a serious problem. There has been no significant increase of other epidemic diseases.

War-shattered cities in continental Europe are also suffering from serious epidemics. Pulmonary tuberculosis mortality has more than doubled in Rome. Epidemics of bacillary dysentery of a severe type and of typhoid fever are spreading in Berlin, where diphtheria, too, is once more on the increase. There were 1,100 cases of typhoid fever during the first three weeks of August. At Helsinki, Finland, there have been 2,472 paratyphoid fever cases up to September 6. Diphtheria remains widespread in the Netherlands where now one-half of the cases occur among adults.

-UNRRA News.

Rural Hospitals

(Continued from page 968)

nurse upon graduation will be better prepared, and, possibly, more prone to accept positions there. Until some such plan as this is evolved, the problem of securing adequate staff for the small community hospital remains on the doorstep of the general nursing group. The advantages far outweigh the possible disadvantage of isolation. Let's go to the rural hospitals!

Multiple Births

It is true that seven infants at one confinement have been recorded. There are six instances of sextets, thirty of quintuplets. Quadruplets occur once in every half million births. Triplets occur once in every eight thousand births, while twins are much more common and occur once in every eighty to ninety births. The probability of premature delivery in multiple births is more than three to one. The incidence of toxemia and antepartum hemorrhage is also higher.

Nursing Education

Contributed by

COMMITTEE ON NURSING EDUCATION OF THE CANADIAN NURSES ASS'N.

The "Two-Year" and the "Four-Year" Nurse

In recent discussions of the possibility of preparing three types of nurses (the assistant, the clinical, and the teaching nurse), periods of training of one, two, and four years have been suggested. Obviously, these lengths of time were approximate, and not meant to be exact to the month. It was suggested, however, that there is no real evidence that three years is the perfect length of time for educating any, let alone all, nurses; and to discuss courses, it was necessary to suggest lengths of time, which would necessarily differ in different lengths of training.

One objection to the "two-year nurse" has been expressed as follows: "She may not know enough about the reasons involved in the adequate care of the patients." It is unfortunately true that the present three-year nurse does not always know enough of these reasons; such comprehension, however, is more dependent on the selection of the students of nursing and the use that is made of their experience than on time "put in" on certain wards. Certainly there is a necessary length of experience but it is suggested that two years may be found long enough when the purpose is definite and the conditions favorable. At least the plan is worth a trial. If the course which has been suggested for the clinical nurse is examined, it will be found to contain five months experience in medicine, which is the maximum

suggested by the Canadian Nurses Association Curriculum of 1932, and four months in surgery, which is one to two months less than suggested by the Curriculum. It contains, in addition, the experience in mental hygiene and psychiatry, in communicable disease, in pediatrics and in public health, which are required by the Canadian Nurses Association, and which surely contribute to understanding of the patient's needs, but which are more frequently than not omitted from the present three-year courses. The times suggested for these latter experiences are not as long as those in the Canadian Nurses Association Curriculum, but at least they are to be included; and we are suggesting a shorter course. We are suggesting, also, one which is not striving, unsuccessfully, to put in more and more from all the fields of nursing; but which is concentrating on producing a good clinical nurse.

Doubts as to the "four-year nurse" have taken this form: "She is to be trained in specialties and, not having much experience in direct care of the patient, will not be capable of directing the two-year nurse in good bedside nursing which is so important." This criticism expresses a complete misapprehension of the suggested four-year course. Its object is to produce a better nurse, not a worse one. In introducing the plan this statement was made: "We are accepting the (present) assumption

that public health nurses should be qualified bedside nurses, and we are adding to this the assumption that all teachers of nursing should be qualified public health nurses . . . at the conclusion of this course the student will be qualified for general staff nursing in either the hospital or the public health field; and will have some practice in either field, or preferably in both (after graduation) before going on to teaching or administrative work in either one." Her preparation for supervision and teaching is to be given on a foundation of thorough training in truly general nursingthat is, in bedside and in public health nursing. The statement "she is to be trained in specialties" seems to imply that she is to be trained only in specialties. Nothing could be more untrue either of the suggested plan or of the one demonstration of it which is in progress in this country. The nurse we are discussing is to have a more, not a less, thorough training in nursing than the three-year nurse has today; she is to study and practice nursing in its several branches for four years. Moreover, public health and psychiatry are no more specialties than medicine and surgery, and, as previously pointed out, they are supposed to be part of a proper training for nursing in Canadian schools. Does

anyone seriously contend that a student will become a better nurse because she has been denied these essential experiences in order that she may become an economic asset by servicing a medical or surgical ward for which proper nursing service has not been provided by the institution which is responsible for doing so? The nurse whose "education" has been limited to medicine, surgery and obstetrics is the nurse who has "specialized", prematurely, and to the detriment of her whole future career.

Finally, there has never been a suggestion that a satisfactory nurse could be prepared without "having much experience in direct care of the patient." The four-year course as suggested (and demonstrated) involves direct contact with the patient in every year. This is however, contact with all types of patients, in the hospital and outside it; and content the full implications of which are brought out by skilful instruction.

Already a certain number of the products of such a course are being tested in the practice of nursing. The reports of patients and employers do not suggest that they lack nursing ability, or fail to grasp the reasons behind treatment. The four-year nurse can be prepared to nurse patients, and to teach others to do so.

Working with Newspapers

Nursing organizations, public health departments, alumnae associations, in fact every branch of nursing at one time or another wishes to make use of newspaper publicity. There are frequent moans and groans when what appeared to the writer to be a perfectly sound article or story is cut down almost to the vanishing point. Usually, nurses have not had a great deal of experience in interpreting their work to the public by way of the press. Everyone who has occasion to do this kind of writing will welcome a recent publication of the National Pub-

licity Council, "Working with Newspapers". The author, Gertrude Simpson, is an experienced journalist who has had charge of publicity work with various welfare organizations. Her sound advice on how to get and hold reader interest, how to know what phase of the agency program is news, how to work this news into the right department of the newspaper, how to find out how effective the newspaper publicity is, make this one of the most useful handbooks available. The price is only 75 cents and the Council's address is 130 East 22nd St., New York City.

Notes from National Office

Contributed by GERTRUDE M. HALL

General Secretary, The Canadian Nurses Association

General Meeting - 1946

The biennial meeting of the Canadian Nurses Association will be held July 1-4, 1946, inclusive, with June 29 and July 5 given over to meetings of the Executive Committee. The meetings will be held at the Royal York Hotel, Toronto. Watch for future announcements regarding this meeting.

Personnel Policies and Practices at Home and Abroad

We are pleased to note the inclusion, in this issue of the Journal, of a copy of the report of the Australasian Trained Nurses' Association personnel policies, as contained in the September, 1945, Journal of the Royal Victorian College of Nursing. The nurses of Australia have, in this excellent presentation of living and working conditions as they concern every branch of nursing, set a pattern which nursing organizations in other countries might very well emulate.

A beginning along this line has already been made by one of the provincial associations in Canada by the setting up of personnel policies, salary schedules, etc., in respect to hospital nursing. Such foresightedness is most timely, especially in view of the increasing unrest among members of the nursing profession regarding hours of work, remuneration, etc., and in view of the movement among labour unions to at-

tract nurses to affiliate with these unions. It, therefore, behooves every nurse to become informed of the plans of her provincial registered nurses' association for securing satisfactory working and living conditions.

State Aid for Post-Graduate Study

The following announcement, entitled "Open Scholarships for Tutors", appeared in the October 6, 1945, issue of the British Nursing Times:

The nursing profession will welcome the announcement that the Ministry of Health is offering financial assistance to nurses who wish to qualify as sister tutors and male tutors. The scholarships will cover training and examination fees, and will also include an allowance of £150 for the period of training, payable monthly in arrear, towards maintenance, cost of books and travelling expenses. These scholarships will allow nurses to support themselves while they qualify without incurring debts in the form of loans, etc. Holders will be required to give an undertaking that they will serve as qualified sister tutors for at least two years, assuming that they pass the examination. They must have had three years postregistration experience in hospital, and must apply to the Secretary, Ministry of Health, Division 4A (8), Whitehall, London, S.W.I. We regret that the three years experience must be "in hospital". Experience outside hospital is broadening and invaluable to the teacher, who will not only prepare nurses for institutional work.

This information may be used to good advantage by those who are seeking to inform members of the government and the public on the need for financial assistance for nursing.

Nation-Wide Action in Field of Nursing

A comprehensive program for nation-wide action in the field of nursing in the United States has been prepared and issued in booklet form by the National Nursing Planning Committee of the National Nursing Council for War Service. This was prepared as a blueprint for action and it is pointed out that in order to make the program, as outlined, effective, all state and local groups must participate. Comments, suggestions for readjustment and criticisms are invited by the Planning Committee.

It is suggested that small groups should be formed to study the proposals and to assist in launching plans for projects suggested in the outline. It is also pointed out that the program outline is not a finished product. It must constantly grow and change to meet the needs as they develop rapidly during the transition period ahead.

Report of the Committee on the Training of Nurses for the Colonies

Several copies of the Report of the Committee on the Training of Nurses for the Colonies, recently published by His Majesty's Stationery Office, London, have been received by National Office. The committee responsible for the report was set up in November, 1943, to examine the question of the training—both in Great Britain and overseas—of nurses who are to serve in Colonial territories, and to make recom-

mendations, having regard also to the need in those territories for increased public health activities and for the fostering and development of community welfare. The committee consisted of the chairman, Lord Rushcliffe, a vice-chairman and fifteen members, six of whom were nurses. The report gives a short history of the growth of medical and nursing services in the Colonies, and makes wide and detailed recommendations for future development.

Copies of this report are being secured from the United Kingdom Information Office, Ottawa, and will be supplied to all provincial associations.

Clothing for Nurses of Holland

The response to the appeal for coats and capes, etc., for the nurses of Holland has been most gratifying. At the time of going to press, several boxes containing 958 coats and 273 capes were packed and ready for shipping on November 1. Indications are that we shall not only reach our objective but shall go over the top.

The International Council of Nurses has written requesting that we consider the possibility of sending food parcels to individual Dutch nurses. It was stated that individual packages, sent parcel post, reach their destination without loss, although the time required is approximately six weeks from mailing date. The following suggestions were made as to contents: soap, rice, Klim, powdered coffee, tea, chocolate, jam or jelly, Spam, salt and dehydrated soups.

Lists of names and addresses of Dutch nurses are being obtained and will be supplied to the provincial associations. Enquiries should be made from the executive secretary of the provincial association as to details of procedure.

Postwar Planning Activities

Contributed by

POSTWAR PLANNING COMMITTEE OF THE CANADIAN NURSES ASSOCIATION

Nursing Sisters Return to Civilian Life

Nursing sisters are being demobilized. As they return to Canada, we are so happy to see them again and, in spite of hardships and strain to which they were subjected in theatres of war, they look remarkably well. While they speak with spirit and satisfaction regarding their experience overseas, they express their eagerness to get settled into civilian nursing life again.

The brochure which was prepared by your Postwar Planning Committee evidently has served its purpose. Many nursing sisters have spoken of its instructional value in providing information regarding rehabilitation benefits, service opportunities, and university courses available in Canada. Many letters of thanks have been received by the secretary of your Committee, extending thanks to the C.N.A. for the guidance provided in this valuable document of information. It is gratifying that the preparation of this material has been a worthwhile effort.

It must be realized that after four or more years in military service abroad, divorced from civilian nursing, nurses upon their return to Canada find themselves unfamiliar with conditions. War has brought about so many changes, unknown to them, and they feel the need of orientation. A process of adjustment is inevitable.

There is sufficient evidence to indicate that the adjustment which returned nurses must make varies with the individual. It would seem to depend upon interests, past nursing experience, previous specialization, if any, and to what extent preliminary thinking has been done as to a plan for the future.

Several nurses have considered themselves fortunate in securing desirable positions immediately upon demobilization. The positions which they desired were waiting for them. Others decided to take advantage of the educational benefit plan for veterans provided by the Federal Government for post-graduate work.

One hundred and sixteen returned nurses are enrolled in the several university schools. While the largest number are taking courses in public health nursing, there is a substantial enrolment in administration and teaching in hospitals and schools of nursing. Concentration on lectures and study is a vastly different experience to active service overseas, and while some confess the difficulty of adjustment, from observation and report, they are settling into their new situation with the same earnestness and spirit that characterized their services overseas. One student is quoted, "I wish I had taken post-graduate work before going overseas sociology, economics, psychology and principles of teaching would have helped me a lot".

Many nursing sisters not yet demobilized are preparing to undertake postgraduate study next year. Guidance which they have received and acknowledged as to what nursing work would be most purposeful in the interval is expressed in the following excerpt:

I took your advice and reported to the Victorian Order of Nurses in Ottawa. I

am going to Toronto for the two-month course and then will be posted to a district. I appreciate so much your suggestion that I apply to the V.O.N. for experience this year.

A number of nursing sisters were unable to enrol this year and there is concern as to whether some of this number may be deprived of the educational benefit because of the clause which states that educational courses must be started within fifteen months from the date of discharge. This same factor may again operate in the case of the large numbers who have signified their intention of attending universities next year and may not be admitted because of lack of accommodation. In the light of this possibility, the following resolution passed by the Canadian Hospital Council is most timely:

Rehabilitation Courses for Nurses: Whereas there is not only a serious shortage of graduate nurses on hospital staffs but there may also be some difficulty in providing adequate post-graduate facilities for those returning nursing sisters who desire to take special courses;

Be it resolved that the federal government be respectfully requested to permit returning nurses desiring to take post-graduate courses to postpone this utilization of rehabilitation funds for up to two or three years from discharge. It is further suggested that the granting of such post-ponement of rehabilitation aid be made contingent on the nurse being employed in the interval in that field in which she proposes to specialize.

In support of this resolution, the Postwar Planning Committee has also submitted a resolution to the same effect, and it is hoped that before this issue of the *Journal* appears the resolution will be approved by the Executive Committee of the C.N.A.

Some returned nurses tell us of their indecision and frustration in undertaking post-graduate work immediately up-

on their return, when civilian and D.V.A. hospitals are in such urgent need of nurses. However, in taking the long distance view, shortage of graduate nurses for hospital nursing service has been an unsolved problem for years and it would seem short-sighted if veteran nurses who are eligible did not appreciate and take advantage of the exceptional opportunity afforded to them to undertake special preparation for executive positions in the fields of their choice. In the end, nursing will profit more, and the nursing profession will be richer in leadership.

It has been assumed in several quarters that nursing sisters, upon demobilization, should volunteer in the services in which shortage of nursing personnel has been most serious, particularly tuberculosis and psychiatry institutions. If this expectation be not realized, it should not be considered as due to "total indifference" as to their "path of duty". Careful reflection is necessary. Can we expect that a substantial number of nurses will volunteer for service in any field in which they have not had a basic preparation? Many of us can turn the question to ourselves, and admit that in our own experience we have refrained from entering unfamiliar fields. Viewing the situation broadly and objectively, do we not have to acknowledge that the fundamental reason for the apparent lack of interest, on the part of many nurses, in the fields of tuberculosis and psychiatry goes back to the administration of the undergraduate course which, in many instances, does not provide for a basic experience in these important and essential nursing fields? No one can dispute the fact that the development of a positive attitude, and a desire to nurse and specialize in these particular services, can be best brought about by a basic experience that is challenging and satisfying. Wartime problems in nursing have accentuated this weakness in nursing education and it is hoped that, in the revision of our national curriculum to meet rapidly changing and increasing nursing demands in a postwar era, serious consideration will be given to what must be included as essential nursing experiences.

At this time of demobilization when nurses are making decisions as to what preparation they need for reinstatement into purposeful employment, they should be made aware of the increasing demand for the clinical nurse specialist. University schools are offering their co-operation in developing sounder post-graduate clinical courses and they are gradually being organized and administered on an advanced level to prepare experienced nurses for teaching and administrative positions. Graduate nurses who are eligible should be encouraged to prepare themselves to take charge of clinical departments of nursing, and to many demobilized nurses this development should offer new openings for satisfactory civilian nursing service.

MARION LINDEBURGH
National Chairman
Postwar Planning Committee,
C. N. A.

The Australian Nursing Scene

Nurses in all parts of Canada who are serving on committees for the consideration of the various factors involved in working conditions for nurses will be very interested in the comparable developments in the Australian nursing scene. As reported in the September, 1945, issue of Una, the journal of the Royal Victorian College of Nursing, at the second annual meeting of the Employees' Association of the R.V.C.N., a comprehensive report was presented dealing with suggested salaries, hours of work, etc. While no action has been taken on this report as yet by the Hospital Nurses' Board, the recommendations show the trend to be toward the improvement of working conditions. Titles and terminology differ from our customary phraseology but the intent is the same. The following are the principle recommendations with explanatory terminology in brackets:

INSTITUTIONAL NURSES

1. Increase in Salaries: Sister tutors (instructors): 1st yr., £5 — 2nd yr., £5/5 — thereafter, £5/10. Sisters (supervisors): 1st yr., £5 — 2nd yr., £5/5 — thereafter,

£5/10. Staff nurses: 1st yr., £4/5 — 2nd yr., £4/10 — thereafter, £4/15.

- 2. Days off to accumulate: That each employee on the day staff be allowed off duty one day each week, provided that by agreement with her employer such days off may accumulate and be taken in one continuous period at a time mutually agreed upon between the employer and the employee. That the period during which her leave may accumulate shall not be in excess of three weeks.
- 3. Annual leave for staff nurses: That staff nurses be granted four weeks holiday.
- 4. Notice of annual leave: Unless by mutual agreement, notice of annual leave be given to all members of the nursing staff at least one month prior to commencement of leave.

The following reasons were given in support:

Sister's salary: That in view of the responsibility involved in the position of sister, and the proposed increase of salary of staff nurses, it is considered that the salary recommended is the minimum salary which should be paid to a sister.

Sister tutor: The same reason applies to sister tutors. Upon the sister tutor much of the important responsibility of the early training of nurses depends.

Staff nurses: That the existing rate of salary for staff nurses is totally inadequate and allows no possibility of providing for old age.

That in view of the present rate of salary ruling for female attendants under the Hospital and Benevolent Asylum Attendants Board, i.e.: 1st year, £3/8 — 2nd year, £3/9 — thereafter, £3/10 (less 16s. for board and lodging); strong disapproval was expressed of this injustice to qualified nurses, which fact it is considered must ultimately affect recruitment of nurses.

Staff nurses, particularly in private, intermediate and community hospitals, play a very important part in the efficient working of the hospital and their work should receive adequate remuneration.

Charge positions available to nurses in hospitals are limited; consequently the majority of nurses, particularly on the staffs of private, intermediate and community hospitals, remain "staff nurses" for many years, yet upon these nurses depends so much of the good nursing carried on in these particular institutions.

INFANT WELFARE NURSES

Sister Infant Welfare Centre (public health nurses) — Uniform salary of £6 per week.

1. Part-time: A part-time nurse shall be paid in respect of any part-time work not less than £1/5 per day or a proportionate part of the ordinary rate prescribed for a permanent nurse for an ordinary week's work, whichever is the greater.

Where a part-time employee is necessarily absent from her usual place of residence on account of her duties she shall, in addition to the wage prescribed, be paid 10s. for each night so absent. Such additional sum shall be deemed to include allowances for board and lodging.

- Casual: A casual nurse shall be paid not less than 4s. per hour with a maximum of 30s. for each day she is called upon to work.
- 3. Hours of work: (a) The number of hours which shall constitute an ordinary week's work shall be 38; (b) work done in excess of 38 hours shall be overtime; (c) a day shall consist of 7 hours duty time.
- 4. Annual leave: Each employee shall be entitled to eighteen days annual leave on

completion of each year of service without deduction of pay.

5. Uniform allowance: An employee after three months continuous service shall be entitled to a payment of £5 as a uniform allowance, and on the completion of the first three months in each and every subsequent year of service she shall be entitled to a further uniform allowance of £5. The cost of laundering all uniforms shall be paid by the employer.

The following reasons were given in support:

Hours of duty: In support of the request for reduced hours of work it is contended that the nurse in industry must conform to conditions provided by any Award, Determination or Agreement for the general body of employees in the industry in connection with which they are employed. Consequently infant welfare nurses should be granted the same hours of work as other municipal officers, i.e., 38 hours working time.

That the nurse engaged at an infant welfare centre does not complete her duties when the centre officially closes — she has her reports to write and entry of daily records which are important and must be kept for the purpose of statistics for the Government Statist. In addition, she has the centre to set in order and miscellaneous duties to perform before being free to leave.

Salary: It is contended that all sisters engaged in infant welfare centres, etc., have an equally high responsibility and consequently should receive the same salary.

That the duties of the nurse engaged in infant welfare centres include teaching and training of mothers, which should be recognized as a very exacting educational as well as a nursing service.

That the nurse engaged in infant welfare work has to provide her own board and accommodation which, owing to high cost of living, cannot be obtained at 30s. per week.

That the nurse carrying on the work of an infant welfare centre is actually a pioneer in the field of preventive medicine. She has the added responsibility of recognizing as such the healthy and the sick child and has to advise the mother when medical attention is necessary. Therefore to be in a position to give this advice she must have highly specialized knowledge in the health of children.

That, unlike the institutional nurse, she

has to spend time in travelling to and from the centre.

It is contended, by nurses engaged in infant welfare work, that a serious anomaly exists as no provision for part-time workers is made unless they are to be regarded as casual employees. If this be so they are entitled to 28s. per day, whilst a nurse coming under Clause $6\ (b)$ of the Determination receives less than £1 per day. The latter nurse has no compensation for loss of time or long travelling hours, and the conditions are far more arduous than for a part-time worker for one municipality or employer.

INDUSTRIAJ. NURSES

Salary: It is recommended that the salary of the nurse engaged in the industrial sphere shall be as follows: 1st year, £5 per week, with annual increments of £13 (5s. per week) until the nurse receives a salary of at least £6 per week.

The following reasons were given in support:

Salary: That in view of the high cost of living and based on the salary of the sister on the staff of a hospital, the rate of salary granted is not adequate. Further, the nurse in industry should receive annual increments as provided for nurses in institutions. It is contended that, as in the case of the institutional nurse, the value of the nurse in industry increases with her years of service. That, unlike the institutional nurse, she has to spend time in travelling to and from her work.

OTHER IMPROVEMENTS

It was ascertained that, in connection with a course in post-graduate training, trained nurses were working junior to the nurses who were not general trained nurses. Through the efforts of the Employees' Association this practice has been rectified; also in the same institution, post-graduate students now receive the salary of the staff nurse.

Risk allowance: The question of risk allowance was discussed briefly by the Hospital Nurses' Board but it was contended

that this would be difficult to determine as, through the various wards of hospitals, patients might be found to be suffering from some specific disease. Until able to be transferred to a special hospital various nurses might attend the same patient throughout the day. Then it was contended that, in the infectious wards as everv precaution is taken by the nurse, the risk less than in the general ward where the disease may not be detected. Further as the outcome of the proposals put forward by the Student Nurses' Association, it is anticipated that compensation will be paid to nurses who contract tuberculosis or some allied disease in the execution of their duties, and this should to a great extent meet the situation.

OTHER PROPOSALS BROUGHT TO THE BOARD

Roster of hours: In view of complaints received that in many instances due notice of off duty hours is not given, thus preventing the nurse from making any plans for recreation, it was decided to approach the Community and Private Hospitals' Associations asking them to bring the matter before the members of their associations. The committee suggested that a clause be inserted in the Determination to cover such, but it was decided after considerable discussion at an extraordinary general meeting to try other means rather than enforce its observance through the Determination of the Hospital Nurses' Board.

Another matter brought to the notice of the Board for consideration was the position which may arise in regard to the salary paid to the sister who acts for the matron when she is off duty. It was pointed out by a matron that, where a sister is required to hold three certificates in connection with her duties and take charge while the matron is off duty, she receives payment for additional certificates and in addition special rates "at call" thus receiving the same salary as the matron.

Members of the committee felt these suggestions should receive the utmost consideration, but were of the opinion that they were so far reaching they should be dealt with and considered in the planning of postwar nursing construction.

Interesting People

On October 1, 1945, Helen Margaret King was appointed assistant director of the Vancouver General Hospital School of Nursing, replacing Catherine Clibborn, who, after occupying that prosition most successfully for two years, resigned to be married.

Miss King was born in Middlesex, England, where she received her early education. After graduating from the school of nursing of the Vancouver General Hospital in 1927, she occupied several important positions in her own School, at the Tranquille Sanatorium, and at the hospital at Williams Lake, B. C. In 1942-43, she enrolled for the course in teaching and supervision at the McGill School for Graduate Nurses, returning to the Vancouver General Hospital as clinical instructor in the obstetrical department. Miss King lives with her parents in Vancouver, where much of her spare time is spent in gardening and very excellent cooking.

By her outstanding teaching ability, her interest and enthusiasm in the welfare of the students, and her unusual power of adaptability, Miss King is making a fine contribution to nursing



Bridgman's Studio, Vancouver

HELEN M. KING

at its best. Her appointment is of great interest to the members of her Alumnae Association and to her many friends who wish her every success in her new position.

Helen Mildred McDonel was recently welcomed to the Winnipeg General Hospital School of Nursing as their first educational director. Her work includes responsibility for the planning of all class schedules; organization of courses of study; planning for faculty conferences and teaching.

Born in Ohio of Welsh parentage, Miss McDonel received her B.A. (cum laude) from Wooster College, After an interval of high school teaching, she launched upon her nursing career, graduating from the D. Ogden Mills School of Nursing, Nudeau, N. Y., in 1928. For the following seven years Miss McDonel was instructor in and supervisor of pediatric nursing in the Western Reserve University School of Nursing, Cleveland, Ohio. She later associated herself with the nursing education programs in other universities, first, at the University of Denver, Colorado, where she was also assistant dean at the Children's Hospital School of Nursing. In 1940, Miss McDonel received her M.A. from Western Reserve University and afterwards was assistant professor of nursing and assistant director of the Out-Patient Department, Medical College of Richmond, Virginia. Immediately prior to coming to Winnipeg, Miss McDonel was educational director in the Methodist Hospital, Indianapolis, Indiana.

Added to the assets from this broad experience, Miss McDonel has served on the Committee on the Care of the Child, National League of Nursing Education, and has taken an active interest in state nursing association work. We welcome her to Canada and trust in her present busy life she may find opportunity to



HELEN M. McDonel.

pursue her chosen avocations of music, art, and outdoor activities.

Flora Aileen George, who until recently was matron of Ste. Anne's Hospital (Department of Veterans Affairs), Ste. Anne de Bellevue, P. Q., has been appointed to the position of superintendent of nurses at the Verdun Protestant Hospital. Miss George, a graduate of the Sherbrooke Hospital School of Nursing, took the course in teaching and administration in schools of nursing at the McGill School for Graduate Nurses. Later, she became lady superintendent of the Woman's General Hospital in Montreal, a position which she held for eight years until she was appointed director of the Nursing Service Bureau sponsored by the R.N.A.P.Q. For two years she rendered valuable service as general superintendent of the Victoria Public Hospital in Fredericton. N. B.

Miss George is actively interested in the work of nursing organizations and has served the R.N.A.P.Q. as a member of the board of managers, and of the board of examiners, as well as chairman of the Hospital and School of Nursing Section. Her many friends wish her all success in the important task which she has undertaken.

Margaret Irene Brady has recently



Don's Stateos

FLORA A. GEORGE

severed her connection with the Child Welfare Association of Montreal to assume the duties of supervisor of nurses with the Department of Health of the City of Westmount, P. Q.

A Nova Scotian, Miss Brady received her B.A. from Acadia University, Wolfville. She graduated from the Royal Victoria Hospital School of Nursing, Montreal, in 1932. The following year, on a scholarship for post-graduate work provided by the R.N.A.P.Q., Miss Brady took her course in public health nursing at the McGill School for Graduate Nurses.

Miss Brady has served her provincial nurses' association as chairman of the Public Health Section and as convener of the Publicity Committee. At present she is vice-chairman of the English-speaking chapter of District 12 of the R.N.A.P.Q.

Edith Irene Stocker has been appointed as superintendent of the General Hospital, Kelowna, B. C., combining the functions of administrator and supervisor of the nursing services.

A native of Manitoba, Miss Stocker graduated from the Winnipeg General Hospital in 1924. For six years she served as night supervisor and assistant superintendent at the General Hospital, Moose Jaw, Sask. In 1932, developing her special interest in tuber-



MARGARET L. MOAG

culosis. Miss Stocker obtained the certificate given by the Saskatchewan Anti-Tuberculosis League and was appointed superintendent of nurses at the Sanatorium in Saskatoon. In 1936, she became supervisor of the Vancouver Unit of the Division of Tuberculosis Control, which position she relinquished to become field secretary with the Canadian Tuberculosis Association. Further study at the University of Toronto School of Nursing was rewarded by a certificate in hospital administration. With this additional preparation, Miss Stocker became superintendent of nurses at the Sanatorium, Ninette, Man.

Miss Stocker has always taken an ac-



LOUISE DRYSDALE

tive interest in association activities in Saskatchewan, Manitoba and British Columbia. She is an enthusiastic golfer and a devotee of motoring.

Culminating a long and exceedingly useful career, Margaret Laura Moag is tiring at the end of the year from the position she has occupied since 1923 as superintendent of the Greater Montreal Branch of the Victorian Order of Nurses.

A graduate of the Kingston General Hospital, Miss Moag served with No. 3 Canadian General Hospital in France and in other hospitals in England during the first World War. After demobilization in 1919, she accepted a post with the Soldiers Civil Re-establishment Service in Ottawa and remained there until coming to Montreal. Miss Moag's interest in public health nursing antedates her war experience. A graduate in public health of the School of Applied Social Sciences of Western Reserve University. Cleveland, she was on the staff of the Detroit Department of Health for several years.

Miss Moag's contributions to nursinghave been many and varied. She has served on numerous health and social service committees, has been president of the Registered Nurses Association of the Province of Quebec and, in national nursing, was chairman of the Public Health Section and second vicepresident of the C.N.A. She was one of the delegates representing Canada at the International Congress of Nurses at Helsingfors, Finland, in 1925 and again in 1937 at London. During the latter visit, she had the honour of being presented to Their Majesties, Queen Elizabeth and Queen Mary, at Buckingham Palace. She is also an active member of the Business and Professional Women's Club in Montreal.

Miss Moag will be greatly missed from Montreal when she returns to her home in Smiths Falls, Ontario, where she plans to devote some of her time to her music—she was an accomplished pianist years ago—catch up with her reading, and do a bit of gardening. May her years of retirement be full of happiness for she leaves a job well done.

Louise Drysdale has retired from the nursing profession to take over the ownership and management of the Willingdon Tea Room in Vancouver. Trained at the Royal Columbian Hospital in New Westminster and the University of British Columbia, for nineteen years Miss Drysdale was a public health nurse in Vancouver schools and, for the last few years, was supervisor of Unit No. 2 of the Metropolitan Health Service, Vancouver.

New kinds of contacts with the public, struggles with rationing and government controls, in fact all the variety of the business world are providing much interest and stimulation for her.

Ellen E. Love, M.B.E., has retired from the position of superintendent of nurses at the Fort Qu'Appelle Sanatorium. Miss Love, who was born in Seaforth, Ontario, is a graduate of the Winnipeg General Hospital. Following service in the first World War, she joined the nursing staff at Fort San. When the Saskatoon Sanatorium opened in 1925, Miss Love became the first lady superintendent. For the past ten years she has held this position continuously at Fort San. In 1943 Miss Love was awarded the M.B.E. and this year has accepted an

honourary life membership in the Saskatchewan Registered Nurses Association.

At a dinner held in her honour at Fort San, tribute was paid to Miss Love for her faithful service with the Saskatchewan Anti-Tuberculosis League; guests were members of the staff who were associated with her. Her many friends and colleagues wish Miss Love all happiness and good health in her retirement.

Anna Connor has resigned from the staff of the Public Health Nursing Division of the Department of Public Health, Toronto. Miss Connor graduated from St. Michael's Hospital School for Nurses. Previous to entering the public health nursing field she did private duty nursing and was assistant registrar at the Central Registry for Graduate Nurses, Toronto, Miss Connor had a broad experience in district public health nursing, in hospital health services, and as district superintendent. She has guided many nurses, both students and staff, in a kindly way, and a wealth of good wishes are extended to her that she may enjoy, to the full, the years ahead.

Obituaries

Madeline Anderson died recently in Moose Jaw. Miss Anderson served as a nurse during the Boer War, in which she received wounds, and in World War I. South African War veterans had charge of her funeral.

Mrs. Anna Mary (Murray) Ross died on September 24, 1945. Mrs. Ross was a graduate of Mt. Clemens Sanatorium, Michigan, and she nursed for a number of years both in Saskatchewan and British Columbia. Gladys Young died on September 5, 1945, in Halifax, N. S., after a lengthy illness. A graduate of the Class of 1922 of the Victoria General Hospital, the late Miss Young was a highly esteemed and valuable member of the hospital staff, having acted in the capacity of head nurse on the third floor of the Private Pavilion for four years. She was later appointed as night superintendent of the main hospital, which position she held for nineteen years until the time of her retirement in May, 1944.

STUDENT NURSES PAGE

The Student Nurse and the V.O.N.

A. ELIZABETH SCOONES

Student Nurse

School of Nursing, Vancouver General Hospital, B.C.

Student nurses are very fortunate when they have an opportunity for affiliation with the Victorian Order of Nurses. Experience with this national order of public health nursing is of great value in developing interests and understanding outside the immediate care of patients in hospital. But it does not end there. It gives a very valuable introduction to the field of public health.

The Victorian Order of Nurses, now nearly half a century old, has for its primary objective the giving of bedside nursing care in the home, combined with health teaching. It is of great service to the community, caring for the health needs of the rich and poor alike, regardless of race, colour, or creed. It works in close co-operation with the hospital, and the various community health and welfare agencies. All cases nursed by V.O.N. staff must be under the care of a physician who, of course, prescribes all medication and treatment.

Every morning shortly after 8 o'clock, after the day's cases were listed and their records sorted out, the fleet of V.O.N. cars would leave the head-quarters, each with one or two public health nurses and a student. The familiar black bags containing all necessary equipment would not be forgotten. The day's work was always carefully planned to conserve gasoline and prevent waste of nurses' time. Off we would go driving

through sections of half asleep city to the district.

First there were usually diabetic hypos to be given - perhaps to an old Chinaman living in a wobbly rooming house, or perhaps to a busy little housewife anxious to learn how to do it herself. Then there would be the maternity cases-home confinements are rare nowadays because hospitals are more convenient for the doctors and for the patient. However, there are some mothers who are only too glad to be home after a few days in the hospital and let the V.O.N. do the rest. This care consists of bathing the baby in the presence of the mother, explaining every step, then giving obstetrical and general care to the mother. Many young mothers are very grateful to the V.O.N. for coming in for three or four mornings to bath the baby and explain the important points in new-born care. The rest of the morning would be spent in giving general care to a variety of patients. To an old age pensioner who had had a stroke, we would give a bed bath and an enema explaining to his wife facts about his diet, elimination, and the care of his skin. For an old lady with advanced carcinoma of the breast we would change her dressing and make her comfortable. There would be arthritic cases and many other types of medical and surgical patients. They are all appreciative and wonder about paying for the service. For those who can afford it, one dollar is charged per nursing visit but there is a sliding scale for those who cannot pay in full. The V.O.N. does not rely on the fees of patients for carrying on the work as civic and governmental authorities and the community chest make annual grants.

The afternoon would be spent largely in giving pre-natal advice on matters of diet, exercise, elimination, signs and symptoms of complications, and preparation of the baby's equipment, to the expectant mother. These patients are all urged to have early regular medical supervision. Then there are the babies to weigh and the mothers to be advised about breast feeding, baby rashes, weekly gain, etc. New-born supervision is given until the baby is six weeks old and ready to attend well-baby clinics. Often there would be a sick child to go and see. We would take the temperature, examine

for rash, and, if necessary, advise the mother to call the doctor. These instructive visits cost nothing and the results are seen in the healthier generation of Canadian children growing up today.

Our work as students was largely observation. As well as seeing for ourselves what was being done and helping with nursing care, we were given lectures on the keeping of records which any organization must have in order to run smoothly and efficiently, and lectures on the medical and social resources in a community such as ours. All of us, in addition to enjoying the work, at first because of the novelty and later because of the value, find that we can understand the average hospital patient so much better and give him more than just plain nursing care. We feel far better equipped to give him sound health teaching and advice as to where to turn with his own and his family's difficulties.

Well Done, Student Nurses!

In the February, 1945, issue of the Journal we carried a story of the campaign conducted by the student nurses in the Homoeopathic Hospital, Montreal, to bring their total of student subscriptions up to 100 per cent. During the intervening months, a number of other schools of nursing have joined the proud number of those in which all the students have become subscribers, either individually or sharing a subscription with a room-mate. The most recent group to become 100 per cent subscribed is the student body of the school of nursing of St. Paul's Hospital, Vancouver.

Why should student nurses subscribe to the national nursing Journal? As one of their best sources of information, both scientific and professional, they need to have ready access to The Canadian Nurse. But, you say, our school subscribes — it is in our library. Yes, it is

there, but do you ever read it unless you have a definite assignment? We heard of one school where the Journal was kept on a chain lest it disappear. The incentive to read is lost. But, to have your own copy, to have it right beside your bed where you can take a glance at it before you drop off to sleep, to mull through it in your hours off-that is the way to become thoroughly acquainted with the Journal. Student nurse rates of eighteen months for two dollars may be applied right up to the day any student completes her training. Take advantage of this rate. Receive your own copy of The Canadian Nurse. Keep up to the minute with what is going on in every part of Canada. And let us know when your student body subscription list equals that of the students of St. Paul's. We will tell them about your school.

-M.E.K.

Letters to the Editor

With UNRRA in Germany

Perhaps you would like to have a little bit of information about the work here, and also about the Canadian nurses so that you can put a news item in the Journal. I do think we should have all the publicity possible. My official title is UNRRA Chief Nurse, British Occupational Zone. This Zone is divided into three districts and, as far as the nursing organization is concerned, in each district we have a district nursing supervisor. Under her we will soon have appointed field nursing supervisors who will have the immediate supervision of the nursing activities of anywhere from four to ten teams. Experience over here has taught us that all UNRRA nurses down to, and including, team level are really supervisors. For example, an UNRRA team has control of a group of Displaced Persons. This group may be anywhere from twelve hundred to five or more thousand. Obviously all of these people are not located in one building; they may be in many camps scattered over an area having a radius of as much as twenty miles. Therefore it is the job of the UNRRA nurse to organize and supervise nursing activities within the Centre, as we are trying to stress the public health aspect of the program. Where do we get the nurses, because we are not engaging UNRRA nurses for work any lower than team level? As I visit the teams I am told that there are so many Displaced Persons "nurses" working. Just as soon as my field supervisors are appointed they are going to get accurate details as to the qualifications of these people. I very much doubt that any considerable portion of them are really qualified nurses. We may, therefore, have to have some teaching program for nurses' aides.

Our hospital policy is not definitely defined as yet, but we are anticipating using German civilian hospitals in which the nursing is done by the German nurses. In any of those hospitals which I have visited to date the D.P. patients seem to be getting the very best of care, and the German nurses are really devoted to their task.

Each Assembly Centre has its own particular problems, and no one program can be

set down. We can only work on general principles. So far we feel that the team nurse is responsible for organizing a child health program, ante-natal clinics, instructions to mothers in regard to the care of children, supervision of the children's feeding and all other aspects of the modern public health program as we know it. My feeling to date is that the best way to try to improve the health standards of Displaced Persons is through the professional members of their own group. That is why we are going to endeavour to retain as many of the qualified D.P. nurses as possible. The team nurse is also responsible for visiting the German hospitals, in which there are D.P. patients. to supervise all nursing aspects of the care given.

That, roughly, is our organizational set-up. As a matter of fact I am still waiting for one district nursing supervisor, as I am hoping very much that an American who is now stationed in the American Zone will come over. The supervisors in the other two districts are Australian and English respectively. Our ideal of mixing members of the team as to national groups was really much too idealistic, but I do believe that it is a good idea to have a supervisory group as representative as possible, and thus, in the meetings which we will be holding, we can really get many different views.

You will probably be interested in knowing who the Canadian nurses are who are in this Zone. In addition to myself we have Janet Brenton, Margaret Inglis, Jean Lazecko, C. L. Bartsch, and Nora Madden. These nurses came up from Italy about June 1. Norena Mackenzie is in London and is coming over here just as soon as she can get her passage. The remainder of the Canadian group arrived recently and included Germaine Bernadin, Agnes May Dunn, Frances Pearl, Lilian Rankin, Mary Wade, Jean Watt, Edna Osborne, and Janet Vanderwell, and I believe there is one other Canadian waiting in London to come - Marjorie E. Lownds. I am drawing from the Canadian group for some of the field nursing supervisors but these appointments have not yet been made.

This country is still as beautiful to me as it appeared when we first arrived. I cannot understand why Hitler permitted such destruction. In the country the people seem extremely industrious. Every inch of land is cultivated. They have at last taken in their harvest, but, because we had very heavy rain in August, much of it was spoilt. Right now the trees are beginning to change into autumn colours, and in about a month's time the hillsides should be very beautiful. I had a trip down to Frankfurt, and going through the Hartz Mountains reminded me so much of home. Frankfurt has certainly been a beautiful old city but the destruction has been terrific, and going out of the luxurious hotel into the streets, with rubble piled high and the German workers emerging from their cellars to go to work, was a bit hard to take.

About a couple of weeks ago I was lucky enough to get in a trip to Denmark as we are hoping to get some Danish nurses. Copenhagen was as lovely as I had heard that it was. There is a great shortage of transport, and you are extremely lucky if you manage to get a taxi. Incidentally all the taxis have a wood-burning apparatus on the back as there is no petrol. The bicycle is very much in vogue and the Danes ride their bicycles as though they were born on them; their motions are most rhythmic. It was grand to see the water again, Surprisingly enough the Baltic is as blue as the West Coast water! A few days before I went to Copenhagen I visited some of the camps along the shores of the Baltic in Germany. Many times I really felt I was driving through parts of Canada, especially along some of the parts of Vancouver Island.

A Course in Midwifery

The Department of Public Health is trying to extend health services in Saskatchewan by organizing health units. There are to be about seventeen, covering the more densely populated areas, and will have hospital service, laboratory technicians, public health staff, etc. This, however, does not solve the problems in districts "far from the madding crowd" where no doctor finds it profitable to settle and where it may be too expensive for the Department to put a doctor full-time. As an experiment, nurses with public health training and a course in midwifery are to be tried in aforesaid lost and gone areas.

-LYLE CREELMAN.

The Department is paying for the course for two of us at the Maternity Centre Association of New York which I will briefly describe.

The Maternity Centre Association was formed in 1918 to give nursing care to mothers who could not or would not be delivered in hospitals and among whom the mortality rate was high. While still not a large organization the M.C.A. does considerable work and is now taking in about twelve to eighteen students a year. The course is about six months and gives considerable clinic experience, pre- and post-natal care, and deliveries in the home, which the student first observes, then later performs under the watchful eye of a staff midwife. Anything abnormal which would make delivery in the home impracticable is refused if it shows up in the ante-partal period. Three doctors, who give a day each week to the clinic, make the decision as to whether or not each case is suitable for home delivery. The patient usually has two examinations by the doctor pre-natally-one immediately after registration, the other in the last month-and another examination at three months post-partum. All the other regularly spaced examinations are done by the students in the clinic supervised by staff mdiwives.

Patients have Wassermann and smear, hemoglobin and blood pressure at first examination. X-ray of chest is taken as soon as possible. If blood pressure is high, hypertension treatment is started; if blood is low in hemoglobin, iron is started and possibly liver. Diet is computed on eight-day intake and deficiencies are explained and a better diet urged. Vitamins and iron are routine in the last two months. Over a period of time it has been found that the mother is in better condition post-natally than she was on first admittance to clinic. The laboratory service is being increased to include test for Rh factor to eliminate the rare case that might be a fatality. The service is practically free. The charge of five dollars for the whole service, plus a most reasonable charge for iron and vitamins, places the service within the reach of all parents.

The class work is taken care of by Miss S. Could, instructress, and one of the doctors. We are on night call quite a lot but have no work other than study unless a call comes in. Then off go staff, senior and junior students into the tenements of Harlem, Bronx or east Manhattan. There are two

groups on duty each night, each with the same three "ratings", and a third group must be ready to come back on duty if first and second call have gone out. There is also a consultant midwife who can be called on and one of the doctors is on call also, though they are rarely called unless it is for extra sedation, and occasionally a repair is needed.

It really is a most enjoyable experience and I think the course is one of great value. The association of staff and student is markedly lacking in formality and restraint. The patient is led to think that the student who delivers is the most important of the two Even in the clinic, the staff are only too glad to spend time and care in elucidating any problem to help the student. On week-ends, which are two days entirely on duty one week and the next week two days off, the student has a chance to talk and discuss many things with others. When she is on for the week-end, staff and students share meals and time together. The clinic is situated on East 103rd Street with tenements front, back and either side—a conglomerate of races with their joys and troubles, angers and amusements all on exhibit, as it were. in the street. I find it most interesting. The street itself is playground, nursery, park, and

show for most of the inhabitants. A football game in the street itself, children's games on the sidewalks, older people gossiping from window to window and on steps. A mission two doors down and across has a revival every night with drums and cymbals, shouts and groans. People grow, live, flirt, pray, hate and love in this theatre, the street, in a show that goes on and on. I don't blame the people who spend an evening gazing and calling from the windows. I do myself! (gaze I mean of course).

In intervals we do other things — climb the Statue of Liberty, etc. We were off last week-end and wanted to go up the Hudson but it rained so we did a little more of the city instead. I hope I will not get to like the place too well and not want to go back to Saskatchewan. I don't think there is much danger. My ears just ache for silence sometimes.

-MARY P. EDWARDS

Editor's Note: Miss Edwards has been engaged in public health nursing in Saskatchewan for a number of years. We share her interesting account of the course in midwifery which she is taking in New York.

Nursing Sisters' Association of Canada

The annual meeting of the Winnipeg Unit was held in February at the home of Mrs. J. D. Moulden and took the form of a box dinner. The annual spring tea in June was convened by Emily Parker and realized the sum of \$300. A bridge held in the Fort Rouge Branch of the Canadian Legion Hall netted the war fund \$275. This Unit has worked mainly on behalf of the Women's Voluntary Service in Britain but local needs have not been neglected, contributions being made to the train reception committee and the Red Cross. Special mention goes to Mrs. Margaret Payne who worked faithfully on the train reception committee. Deepest sympathy is extended to her in the loss of her eldest son at Hong Kong. Many returned nursing sisters were welcomed at the Remembrance Day tea.

Since registering under the War Charities Act in 1941 the Winnipeg Unit has raised approximately \$4500. Of this amount \$3200 was sent to the British Women's Voluntary Service and \$500 went to the Red Cross, the balance being distributed as follows: Hong Kong cigarette fund, women's naval auxiliary ditty bag fund, aid to Russia fund, Winnipeg service centre, train reception committee, British minesweepers fund, Greek relief fund, Chinese war relief fund, and homeward bound carnival.

Mrs. Hamblin and family are now in Vancouver. At a luncheon, prior to her departure, she was presented with a suitably framed petit point picture as a token of the Unit's regard. Maud Andrew, of California, formerly a nursing sister of Winnipeg, was also a guest. Mrs. McLeod, of Kamloops,



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B.C., the first president of the Unit, and now an honourary member, was a visitor in Winnipeg last summer. Her niece, N/S Hall who went overseas with No. 5 unit from Winnipeg, has returned and is taking her second year of the pre-medical course at Manitoba University. She received the A.R. R.C. and was mentioned in despatches for her overseas service. May Best, one of the Unit's original members, who has been superintendent of the American hospital in Mexico City since 1926, is now on the staff of the Alameda Hospital, Calif. A prospective new member for the Unit is Mrs. Lebetter, formerly of Yarmouth, N.S. and Ottawa.

The Toronto Unit held a garden party and tea in June at the home of Mrs. E. W. Mitchell. Over two hundred nursing sisters attended, including fifty recently returned from overseas. The hostess received with the president, Mrs. Gilbert Storey, and Matron Mary Shaffner of Chorley Park Military Hospital. The social convener, Mrs. Arthur

Biggar, and her assistants were in charge of all arrangements. Col. Agnes Neill, Matron-in-Chief, R.C.A.M.C., was the guest speaker at the Remembrance Day dinner.

Miss C. J. Stuart's recent visit to Toronto was the reason for a get-together of No. 4 C.G.H. overseas (1915-1918) when Mrs. Driver gave a tea, as did Maud Wilkinson. Miss Stuart was the former superintendent of the Red Cross in Regina. Gladys Sharpe, formerly superintendent of nurses, Toronto Western Hospital, has left for Columbia University to complete her course for the degree of B.Sc. in Nursing, part of which was taken at Bedford College, England. Ethel Greenwood is back in civilian life and now makes her home in Woodstock, Ont. Mrs. George Hanna has retired from active duties with the Emergency Nursing Reserve of the Toronto Branch of the Red Cross. Marion Henderson will spend the winter in Florida and Marguerite Carr-Harris will be in Montreal.

NEWS NOTES

ALBERTA

EDMONTON:

University Hospital:

Over two hundred couples attended the recent annual ball of the University of Alberta Hospital Alumnae Association held in "The Barn". Student nurses and nursing students at the university were also invited. The medical theme was carried out in all decorations, the orchestra pit taking on the appearance of an operating room, Miniature nurses caps, made by the students, were given

Velma Clarke and Elna Eickmeyer headed the committee in charge of arrangements. Patronesses were Helen Peters, superintendent of nurses; Madeline McCulla, director of the University School of Nursing; and Mrs. Jack Morrison, president of the alumnae. Proceeds of the dance will be used to buy a record player for the new nurses home.

BRITISH COLUMBIA

COWICHAN CHAPTER:

A well-attended meeting of the Cowichan Chapter, R.N.A.B.C., was held recently at King's Daughters Hospital, Duncan, when both registered and graduate nurses were represented. The evening took the form of a social gathering in honour of the seven V.A.D.s of the local Red Cross, who have worked so willingly for the duration of the war. They were presented with colonial bouquets by the president. An interesting paper from The Canadian Nurse was read to the members. Mr. C. Giesen, who has recently returned from overseas, showed motion pictures of Peru and New Zealand. Musical selections and refreshments concluded the

VANCOUVER CHAPTER:

Mrs. Grundy, president, Misses Breeton, Hawkins, McCann, Reeve, D. Jamieson, Hockins, J. E. Jamieson, and Mrs. Faulkner, members of the executive of the Vancouver Chapter, R.N.A.B.C., on behalf of the Vancouver Chapter, entertained the nursing sisters and V.A.D.s from H.M.S. Implacable. A drive on Sunday afternoon was followed by dinner. Members of the Council of the R.N.A.B.C. were invited to meet the nursing sisters and V.A.D.s as were the presidents of the alumnae associations of the Vancouver General Hospital (E. McCann), St. Paul's Hospital (Mrs. McKenzie), and Royal Columbian Hospital, New Westminster (Mrs. Blackburn). The place of each nursing sister and V.A.D. was identified at the table by



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Chief Superintendent 114 Wellington Street, Ottawa. a maple leaf and on the leaf rested a "Thunderbird" souvenir spoon of Vancouver. These spoons were the gift of the three alumnaes and were presented to the guests of honour by Miss McCann. On Monday the presidents of the alumnaes went on board the H.M.S. Implacable to present spoons to N/S Colley and the V.A.D.s who remained on duty on Sunday. They were afterwards conducted over the ship. On Monday evening Mmes Grundy, Geddes, Misses McCann, Reeve, Breeton, Hawkins, and J. E. Jamieson were invited to a party on board ship and a tour completed an enjoyable visit. Lieut. Margaret Jamieson is back home, arriving in Canada on the Ile de France. Miss Jamieson was recently mentioned in despatches.

Vancouver General Hospital:

The following nurses are doing post-graduate work in the operating room: E. McCann, formerly instructress at the Royal Columbian Hospital and the V.G.H.; Helen Saunders, recently with the R.C.A.M.C.; A. Holmes, of the Royal Columbian Hospital; Joan Taylor, of the Hospital for Sick Children, Toronto; A. Odegarde of the Saskatoon City Hospital; E. Kenny, of St. Joseph's Hospital, Winnipeg. G. McFadyen, formerly with the R.C.A.M.C., has returned to the O.R. staff. In January Miss McFadyen will attend the University of Washington in Seattle.

NOVA SCOTIA

CANSO:

After a vacancy of several months, the position of Victorian Order district nurse at Canso has been filled by Florence Rand (Victoria General Hospital, Halifax), of Canard, who has gone to take up her duties there. Miss Rand has been on the V.O.N. Halifax staff since July, 1944. She succeeds Mrs. M. Hill who has gone to reside in Hampton, N.B. The Canso district includes Hazel Hill, Canso Tickle and Glasgow Head.

YARMOUTH & SHELBURNE COUNTIES:

Registered nurses in Yarmouth and Shelburne Counties, to the number of twenty-five, have organized and are now a branch of the Registered Nurses Association of Nova Scotia. For some time the nursing fraternity in this area has recognized the value of organizing a permanent group here to further and maintain the interests of the nursing profession and to inaugurate many suggested activities which a combination of unity and action could bring to such a group.

The following are the executive officers of the branch: president, Muriel Rice; vicepresident, Mrs. Paul Trask; secretary, Margaret Boutilier; treasurer, Adelaide Munro.





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Editor's Note: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Gena Bamforth, 54 The Oaks, Bain Ave., Toronto 6.

DISTRICT 1

Снатнам:

Public General Hospital:

At a recent well-attended meeting of the Chatham Public General Hospital Alumnae Association plans were made for a tea and bazaar. Mrs. M. Sheldon and Mrs. J. C. MacWilliam are in charge of the tea and Annie Head will be responsible for the bazaar. A drive is now underway for more subscriptions to the *Journal*.

DISTRICTS 2 AND 3

BRANTFORD:

At the first fall meeting of the Brantford General Hospital Alumnae Association it was decided to divide the members into groups, with a captain for every group. Each group will take turns in being responsible for the program every month. Every section will also try to raise at least ten dollars for the alumnae.

At a later meeting Dr. J. R. Calder gave an interesting talk on his overseas experiences. The members also heard the Rev. G. Deane Johnston who served overseas for five years as chaplain with the army. Among other things, he told of the immediate care of the wounded on the battlefield.

DISTRICT 4

HAMILTON:

A meeting of the Hamilton Chapter, District 4, R.N.A.O., was held recently at the Mount Hamilton Residence with H. Snedden presiding. Squadron Leader Dr. P. Voelker presented to the well-attended meeting, by motion pictures, the methods used in the rehabilitation of the returned soldiers in the military hospitals. A social hour followed.

Hamilton General Hospital:

At a recent meeting of the Hamilton General Hospital Alumnae Association the motion to a change in the Constitution was passed whereby the alumnae fees are raised two dollars per year. Edith Dick, acting director of the Nurse Registration Branch, told of her experiences with the Canadian Hospital unit overseas.

E. Bingeman and E. Ferguson, from the

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Superintendent of Nurses, Toronto Hospital, Weston, Ontario. H.G.H. staff, are taking post-graduatecourses at the University of Toronto School of Nursing.

DISTRICT 6

PETERBOROUGH:

Arrangements have been made with Station CHEX for a "spot" morning broadcast three times a week and once a month for fifteen minutes, in order that the public may become better acquainted with the services that the public health nursing field has to offer.

Ruth Kirkpatrick, Victorian Order nurse, has been granted leave of absence to take a course in public health nursing at the University of Toronto under a V.O.N. scholar-

Civic Hospital:

Evelyn Lawless has been engaged as supervisor of nursing. Mae Renwick, who has completed a course in teaching and supervision at the University of Toronto, is in charge of the surgical department, north pavilion. Evelyn Reid is in charge of the surgical department, second floor, following a course in clinical supervision in surgery at the University of Toronto. Margaret McIntyre is taking a refresher course in obstetrics at the University of Toronto, while Mary Robson and Muriel Langmaid have registered for the course in clinical supervision in surgery.

St. Joseph's Hospital:

Sister M. Loretta is taking a course in advanced obstetrics at the University of Toronto.

DISTRICT 8

Ottawa General Hospital:

Sisters M. Alban, St. Valere, and Madeleine of Jesus recently attended the meetings of the Canadian Hospital Council and the Catholic Hospital Association of Canada held in Hamilton.

Having completed a post-graduate course in surgery and operating room technique at St. Michael's Hospital, Toronto, Sister Andre Marie has returned to the staff as operating room supervisor. Viola Downie is now nurse-in-charge of the Red Cross Outpost in Apsley, Ont.

The following sisters from the O.G.H. are taking the nursing education and administration course at the University of Ottawa: Sisters M. Alban, Helen of Rome, Andre Marie, M. Helen, St. Martial, Raymond de Marie, M. Leonille, St. Honorine, St. Germaine, Elizabeth Marie, K. Bayley, G. Clark, F. Fournier, M. Nadon, and J. Page are taking the public health nursing course at the University of Ottawa, while M. Joyce is at the McGill School for Graduate Nurses.

OUEBEC

MONTREAL:

Montreal General Hospital:

At a recent meeting of the Montreal General Hospital Alumnae Association Dr. A. F. Fowler read a paper entitled "Presenting Newer Aspects of Diabetes". After the meeting a reception was arranged by the entertainment committee for the nursing sisters recently demobilized. A hearty welcome was also given to those recently returned from

South Africa.

Recent graduates who have joined the staff are: Ruth Francis, B.A., in charge of the third floor recently opened in the Private Patients Pavilion, Western Division; E. F. Barnhill, J. E. Donaghy, M. E. Everson, A. M. Hamilton, E. D. Heatlie, E. H. Lisson, J. I. Lisson, E. C. MacDonald, J. I. Morrow, A. F. Shea, on nursing staff, Central Division. Cecil M. MacDonald is now in charge of the S.O.R., Central Division, replacing Isabel Davies who recently resigned. (See P. 897, Nov. 1945 issue of the Journal.)

Mabel Shannon, head nurse in gynecology, Ward O, and Elsie Denman, in charge of eve. ear, nose and throat unit, recently spent ten days in New York City on an educational tour of the hospitals in connection with their

respective services. They made their first flight to and from New York.

N/S Margaret J. McCann received the M.B.E. prior to her departure from England. Miss McCann was decorated for her work under fire in Italy. A recent visitor to the school was Mrs. Jackson (Boyd) Crawford who came to say farewell before leaving to join her husband in India.

Royal Victoria Hospital:

The Alumnae Association recently held its first meeting of the fall when about fifty

nursing sisters were welcomed at a reception by the members of the association. We welcome to our staff: K. Marshall (Ontario Mental Hospital and University of Toronto) as instructor, Allan Memorial Institute; E. Long (Royal Alexandra Hospital, Edmonton, and McGill School for Graduate Nurses) as instructor, Montreal

Neurological Institute.

Elizabeth Hughes is now clinical instructor, women's pavilion. Marguerite McDougall and Rita Ackhurst who, until recently, were with the R.C.A.M.C., are back on the hospital staff-Miss McDougall in charge of Ross 3 and Miss Ackhurst in the main operating room. Evelyn Ward has taken a position with the Youville Hospital, Noranda.

Margaret Mowat, who served with the R.C.A.M.C., is doing post-graduate work in the neurosurgery operating room at the Presbyterian Hospital, New York. Adelaide Haggart, science instructor, spent two weeks at Yale University studying the integration

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SASKATCHEWAN

MAPLE CREEK:

The Maple Creek Chapter recently met at the home of Mrs. Broome to say "Goodbye" to Mrs. L. (Cheeseman) Quick and "Hello" to Margaret Smith. Mrs. Quick and family are leaving for their new home at Creston, B.C. Margaret Smith is back from overseas, having spent three years with No. 8 C.G.H. Compacts were presented to the two guests and a delightful lunch was served by Mmes Broome, Hoffman, and

Nellie Henley, J. MacNeill, and Alice Roberge were recently appointed to the staff of the Maple Creek General Hospital. Mrs. Ella Gunderson, night supervisor, has returned to her home at Golden Prairie, Sask.

MOOSE TAW:

Rev. Sister Bonaventure has been appointed superior of the Providence Hospital.

REGINA:

May Reid has been appointed as supervisor of the newly-opened D.V.A. wing at the Regina General Hospital. Miss Reid served with the R.C.A.M.C. for three years.

SASKATOON:

Lucy Willis was recently the first speaker of the season at the "Choice Nights" organized by the Y.W.C.A. Young Business Women's Group. Miss Willis spoke on "Health in its Broader Aspects".

City Hospital:

A preliminary class of forty-five students recently began studies at the City Hospital. Gerda Schuman, and Ruth Gilroy who was recently discharged from the R.C.A.M.C., have been appointed as clinical instructors. Mabel Barry, who has been with the V.O.N. for the past year, has been appointed as surgi-cal supervisor. Mrs. E. (Gloeckler) Dun-canson has returned to the staff as medical supervisor.

Mrs. J. Porteous, recently discharged from the R.C.A.F., and H. Bright, a member of the staff previous to enlistment in the R.C.A.M.C., are completing administration courses at the McGill School for Graduate Nurses. Mrs. C. (MacKay) Robinson, who has spent the past three and a half years in nursing service in South Africa, will leave shortly for England to join her husband.

BY CECILIA M. KNOX

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YORKTON:

Madeline Farbacher has resigned her position on the staff of the Yorkton General Hospital to be married. A presentation was recently made to Mrs. (Langstaff) MacRae whose marriage took place recently.

WANTED

Vancouver General Hospital desires applications from Registered Nurses for General Duty. State in first letter date of graduation, experience, references, etc., and when services would be available.

Eight-hour day and six-day week. Salary: \$95 per month living out, plus \$19.92 Cost of Living Bonus, plus laundry. One and one-half days sick leave per month accumulative with pay. Employees' Hospitalization Society. Superannuation. One month vacation each year with pay. Investigation should be made with regard to registration in British Columbia. Apply to:

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A qualified Instructress is required immediately for the Portage la Prairie General Hospital. Apply, stating qualifications, experience, and salary expected, to:

Superintendent. Portage la Prairie General Hospital. Portage la Prairie, Man.

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An Instructress of Nurses is required for the Kenora General Hospital. Duties are to commence on February 1. Apply to:

Superintendent, Kenora General Hospital, Kenora, Ont.

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Floor Duty Nurses are required at the Barrie Memorial Hospital. The salary is \$85.00 per month. Apply to:

Superintendent, Barrie Memorial Hospital, Ormstown, P. Q.

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Apply, stating full particulars and qualifications, to: Superintendent, Chipman Memorial Hospital, St. Stephen, N. B.

WANTED

General Duty Nurses are required for a 100-bed Sanatorium. The salary is \$90 to \$100 per month, with full maintenance. Four weeks' vacation with ray is allowed each year. State in first letter date of graduation, experience, ref rences, etc. and when services would be available. And

Miss M. McCort, Supt. of Nurses, Niagara Peninsula Sanatorium, St. Catharines, Ont.

DECEMBER, 1945 997

WANTED

Applications are invited for the following positions in the Hamilton General Hospital:

Assistants for the Delivery Floor — day and night. Salary, \$97 to \$112 per month, plus complete maintenance.

General Duty nurses for Obstetrical Dept. Living in, \$82.50 per month; living out, \$100 per month.

Superintendent of Nurses, Hamilton General Hospital, Hamilton, Ont.

WANTED

Verdun Protestant Hospital desires applications from nurses for General Staff Duty. State in first letter, date of graduation, experience, and when services would be available. Registered Nurses are also required for the position of Assistant Night Supervisor and as Charge Nurses for wards. Apply to:

Director of Nursing, Verdun Protestant Hospital, Box 6034, Verdun, P. Q.

WANTED

A Night Supervisor is required for a 50-bed Maternity Hospital. Apply, stating qualifications, salary, etc., to:

Superintendent, Catherine Booth Mothers Hospital, 4400 Walkley Ave., Montreal 28, P. Q.

WANTED

Graduate nurses are required for General Floor Duty at the Nova Scotia Sanatorium, Kentville, N. S. The salary is \$85 per month, with full maintenance. For further information apply to:

Nova Scotia Civil Service Commission, Provincial House, Halifax, N. S.

WANTED

A competent nurse is required for the position of Operating Room Supervisor. Apply, with references, stating experience and salary required to:

Superintendent, Prince County Hospital, Summerside, P. E. I.

WANTED

A class room Instructress for a 120-bed hospital. Apply stating qualifications, experience and salary expected, to:

The Superintendent, Stratford General Hospital, Stratford, Ont.

WANTED

A Dietitian and a Supervisor for a Tuberculosis Annex are required immediately for the Highland View Hospital, Amherst. Apply, stating qualifications, to:

Business Manager, Highland View Hospital, Amherst, N. S.

Official Directory

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- New Brunswick Ass'n of Registered Nurses: Miss Alma F. Law, 29 Wellington Row, Saint John.
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- Registered Nurses Ass'n of Ontario: Miss Matilda E. Fitzgerald, Rm. 715, 86 Bloor St. W., Toronto 6.

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- Registered Nurses Ass'n of the Province of Quebec: Miss E. Frances Upton, 1012 Medical Arts Bldg.,
 Montreal 25.
- Baskatchewan Registered Nurses Ass'n: Miss Kathleen W. Ellis: 104 Saskatchewan Hall, University of Saskatchewan, Saskatoon.

lottetown.

Provincial Associations of Registered Nurses

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Alberta Association of Registered Nurses

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lottetown Hospital.

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Registered Nurses Association of the Province of Quebec (Incorporated 1920)

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SASKATCHEWAN

Saskatchewan Registered Nurses Association (Incorporated 1917)

(Incorporated 1917)

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Registered Nurses Association

Registered Nurses Association

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Alumnae Associations

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A.A., Calgary General Hospital, Calgary
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THE CANADIAN NURSE

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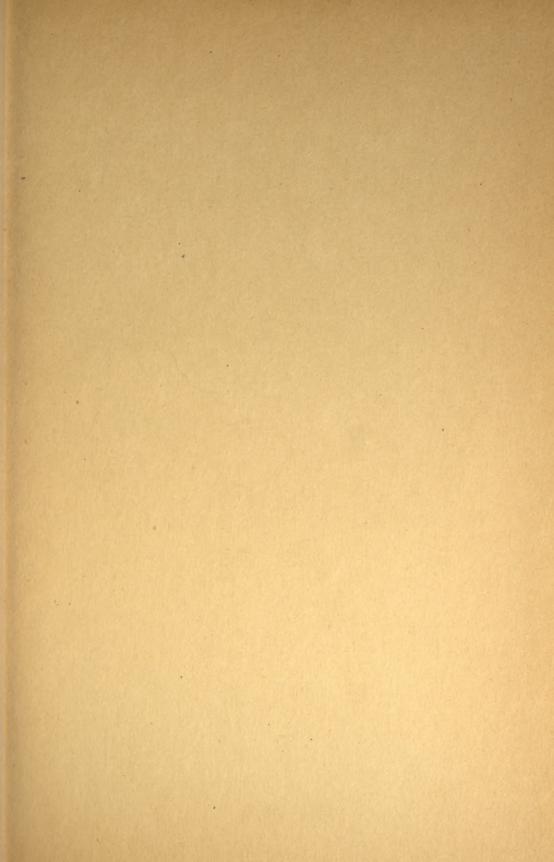
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